OrthoManhattan
485 Madison Avenue, 8th FL
New York, New York 10022

PATIENT INFORMATION
[Please fill in or correct in the appropriate section]

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

PATIENT SOCIAL SECURITY #:_____

HOME PHONE:_____

WORK PHONE:_____

MOBILE PHONE:_____

EMAIL: _____

REFERRING PHYSICIAN:_____
PRIMARY CARE PHYSICIAN:_____
OCCUPATION:_____
EMPLOYER'S NAME:_____

EMERGENCY CONTACT:

NAME:_____
CONTACT #:_____
RELATIONSHIP:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

MEMBER ID#_____

GUARANTOR:_____

GUARANTOR DOB:_____

GUARANTOR SS#_____

SECONDARY INSURANCE: _____

MEMBER ID: _____

WORKER'S COMPENSATION OR NO FAULT

DATE OF ACCIDENT:_____
INSURANCE CO. NAME:_____
INSURANCE PHONE: _____
POLICY #:_____
INSURANCE REP:_____
CASE#: _____

My Appointment today is with (Please Check):

- ☐ O. Alton Barron, MD
- ☐ Louis W. Catalano III, MD
- ☐ Steven Z. Glickel, MD

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have Insurance coverage and assign OrthoManhattan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize OrthoManhattan to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, have been informed that the U.S. Government requires I sign this *Notice of Privacy Practices.* The privacy regulations were created by the *HIPPA Act of 1996* to protect patient privacy. I understand that the full text of the Act is available to me upon request.

SIGNATURE: _____ DATE: _____

CANCELLATION POLICY

I, the undersigned, understand that as a patient at OrthoManhattan I must cancel my appointment at least 24 hours prior to my appointment. Failure to do so will result in a **$50 cancellation fee.**

SIGNATURE: _____ DATE: _____

WORKERS' COMPENSATION ONLY

You may become responsible for the medical costs of treatment for you illness or condition with the provider listed above if (1) you fail to prosecute the claim for workers' compensation or (2) It is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occur, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered. **I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment. NY-WCB A9 (1-07)**

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS ONLY

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to OrthoManhattan for services furnished to me by OrthoManhattan. I authorize any holder of medical information about me to release to the Center for Medical Services and its agents any information needed to determine these benefits payable for related services.

SIGNATURE: _____ DATE: _____

Roosevelt Hand To Shoulder Center
O Alton Barron MD
Louis Catalano III, MD
Steven Glickel, MD

MEDICAL HISTORY QUESTIONNAIRE

DATE _____

_____
First Name Last Name Middle Initial Date of Birth
Primary Pharmacy Name_____ Address_____
What is your height and weight? _____ft. _____in. _____pounds
Dominant Hand: ☐ Left ☐ Right ☐ Both
Date of Injury _____ How did injury occur?_____
Injury/Problem _____
_____
_____

Rate your pain on a scale from 1 (least) to 10 (most). Circle one: 1 2 3 4 5 6 7 8 9 10
Taking Medication for Problem? ☐ No ☐ Yes
If Yes, what medications/dosage? _____
What makes it better? _____What makes it worse? _____
Any prior Treatment? ☐ No ☐ Yes If yes, list prior Doctors or Physical/Occupational Therapists seen:
_____
_____

SOCIAL HISTORY
Alcohol Use ☐ None ☐ Socially ☐ Moderate ☐ Heavy
Tobacco Use: ☐ Never a smoker ☐ Occasional Smoker ☐ Past Smoker ☐ Current Smoker
Tobacco Use Details: _____

PERSONAL HISTORY

Allergies	☐ No	☐ Yes	Steroids	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	History of cancer	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Reflux	☐ No	☐ Yes	Diverticulitis	☐ No	☐ Yes
Peripheral Vascular Disease	☐ No	☐ Yes	Collagen Vascular Disease	☐ No	☐ Yes
Aspirin Usage	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Emphysema	☐ No	☐ Yes
Liver Disease	☐ No	☐ Yes	Ulcers	☐ No	☐ Yes
Colitis	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Do you have a Pacemaker?	☐ No	☐ Yes	Do you have a Stent?	☐ No	☐ Yes

Please list any known Allergies:
_____
_____
_____
Please list any medications/dosage you are currently taking (if you have a list please give to Staff):
_____
_____
_____
_____

Roosevelt Hand To Shoulder Center
O Alton Barron MD
Louis Catalano III, MD
Steven Glickel, MD

Surgery History and Previous Hospitalization: _____
_____
_____
_____

REVIEW OF SYSTEMS (Check any that apply):

CARDIOLOGY

Chest pain	☐ No	☐ Yes
History of Heart Attack	☐ No	☐ Yes
Irregular Heart beat	☐ No	☐ Yes
Known CAD	☐ No	☐ Yes
Murmur	☐ No	☐ Yes

CONSTITUTIONAL

Chills	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Loss of Appetite	☐ No	☐ Yes
Swollen Glands	☐ No	☐ Yes
Night Sweats	☐ No	☐ Yes
Weight Gain	☐ No	☐ Yes
Weight Loss	☐ No	☐ Yes

DERMATOLOGY

Nail Changes	☐ No	☐ Yes
Psoriasis	☐ No	☐ Yes
Skin Cancer	☐ No	☐ Yes
Tick bite	☐ No	☐ Yes

ENDOCRINOLOGY

Cold Intolerance	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Reynaud Symptoms	☐ No	☐ Yes
Thyroid Disorder	☐ No	☐ Yes

GASTROENTEROLOGY

Acid Reflux	☐ No	☐ Yes
Black Stools	☐ No	☐ Yes
Blood in Stool	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Nausea	☐ No	☐ Yes
Vomiting	☐ No	☐ Yes

HEMATOLOGY

Blood Transfusion	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Easy Bleeding	☐ No	☐ Yes
Easy Bruising	☐ No	☐ Yes
Enlarged Lymph	☐ No	☐ Yes

MUSCULOSKELETAL

Arthritis	☐ No	☐ Yes
Back Pain	☐ No	☐ Yes
Joint Pain	☐ No	☐ Yes
Joint Stiffness	☐ No	☐ Yes
Joint Swelling	☐ No	☐ Yes
Morning Stiffness	☐ No	☐ Yes
Neck Pain	☐ No	☐ Yes
Raynaud's	☐ No	☐ Yes

NEUROLOGY

Burning pain:		
Feet?	☐ No	☐ Yes
Hands?	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes
Loss of feeling	☐ No	☐ Yes
Migraines	☐ No	☐ Yes
Pain	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Periph. Neuropathy	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Strokes	☐ No	☐ Yes
Tremor	☐ No	☐ Yes
Vertigo	☐ No	☐ Yes

PSYCHOLOGY

Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
High Stress Level	☐ No	☐ Yes

RESPIRATORY

Chest Pain	☐ No	☐ Yes
Cough	☐ No	☐ Yes
Sinusitis	☐ No	☐ Yes
Asthma/COPD	☐ No	☐ Yes

UROLOGY

UTI's	☐ No	☐ Yes
Incontinence	☐ No	☐ Yes

FAMILY HEALTH HISTORY

Please indicate if any member of your immediate family (mother, father, sister, brother, grandparent or child) has ever been treated for any of the following:

ILLNESS	RELATIONSHIP TO YOU	ILLNESS	RELATIONSHIP TO YOU
Stroke		Colitis	
Seizures		Kidney Disease	
Emphysema		Arthritis	
Asthma		Diabetes	
High Blood Pressure		Thyroid Disease	
Heart Attack		Breast Cancer	
High Cholesterol		Colon Cancer	
Ulcer		Prostate Cancer	

Patient/Parent Signature_____ Date: _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

C.V. STARR HAND SURGERY CENTER
STEVEN Z. GLICKEL, M.D.
O. ALTON BARRON, M.D.
LOUIS W. CATALANO, III, M.D.
1000 TENTH AVENUE, NEW YORK, NY 10019

Appointment Confirmation and Patient No-Show Agreement

As a courtesy, our automated eClinicalMessenger system will call you a few days before the scheduled date to remind you of your appointment. Please follow the prompts to confirm that you have received our reminder.

If we do not receive a response from you, our staff will call you one business day before your appointment with a "live reminder." Cancellations of appointments are not accepted outside of our office business hours.

There will be a $50.00 fee applied to your account for missing an appointment without providing notice at least one full business day before. If an emergency arises and you are unable to notify us within this time, we kindly ask that you provide documentation in order to avoid this charge. Although we do provide the aforementioned courtesy reminders, you are ultimately responsible for remembering your appointment date and time.

_____

Patient/Parent Signature Date