NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

Patient Registration Form

Today's Date: _____

Name: _____ **Sex:** _____

Date of Birth: _____ **Social Security Number:** _____

Phone No: _____ **Email:** _____

Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Please circle: Right-Handed or Left-Handed or Ambidextrous

Were you a: **Driver** **Pedestrian** **Passenger** **On a scooter/motorcycle** **Taxi Driver**

What is the nature of your injury? _____

Occupation: _____

Employer: _____ **Phone No:** _____

Are you still working?

If NO, when was your last day? _____

If YES, Part-Time of Full-Time? Part-Time Full-Time

Emergency Contact:

Contact Name: _____ **Relation:** _____

Phone No: _____ **Email:** _____

Pharmacy: _____ **Phone No:** _____

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

Patient Registration Form

Insurance

No-Fault / Auto Insurance

Auto Insurance Carrier: _____ **Date of Accident:** _____

Insurance Address: _____

Case Number: _____

Adjuster Name: _____ **Adjuster Number:** _____

Attorney Name: _____ **Attorney Number:** _____

Workers Compensation

Workers Compensation Carrier: _____ **Date of Injury:** _____

Did you report this accident to your employer? Yes No

Carrier Claim Number: _____ **WCB Number:** _____

WC Attorney Name: _____ **Phone:** _____

PI Attorney Name: _____ **Phone:** _____

Private Insurance

Primary Insurance: _____ **Phone No:** _____

ID#: _____ **Group #** _____

Insured Name: _____ **Relation to Patient:** _____

Insured DOB: _____ (MM/DD/YY)

Secondary Insurance: _____ **Phone No:** _____

ID#: _____ **Group #** _____

Insured Name: _____ **Relation to Patient:** _____

Insured DOB: _____ (MM/DD/YY)

Lien

Attorney Name: _____ **Attorney Number:** _____

Date of Injury: _____

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

Patient Registration Form

Medical Questionnaire

History and Symptoms

Chief Complaint:

1. How long have you had this problem? _____
2. Was this a result of a fall or accident? YES / NO
   If yes, please give date ____/____/_____
3. Can you work or perform normal activities? YES / NO
   If yes, are there any restrictions? _____
4. Check the symptom(s) associated with your chief complaint:
   _____Pain _____Numbness _____Tingling _____Weakness _____Muscle Spasm

If other please specify:_____

Medical History

Illness	Self	Family	Illness	Self	Family
Diabetes			Heart Problems		
High Cholesterol			Cancer		
Hypertension			Asthma		
Strokes			Seizures		
Glaucoma			Arthritis		
Hepatitis			Thyroid Disorder		
Gout			GI Ulcer		
HIV			GERD Heartburn		

If other please specify: _____

Surgical History (Please list any surgeries you underwent in the past)

Year	Procedure

Height (In): _____ Weight (Lbs): _____

Allergies (Please check any of the following allergies that may apply to you)

Allergy			
	Aspirin		Seasonal
	Seafood		Sulfa Drugs
	Penicillin		No Known Allergies

If other please specify: _____

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

Patient Registration Form

Medications

(Please list any medication(s) you are currently taking, including vitamins and all herbal supplements)

Medication	Dosage	Notes

Social History (Please check if any of the following apply to you)

Social Activity			
	Alcohol use		Drug use
	Tobacco use		Other:

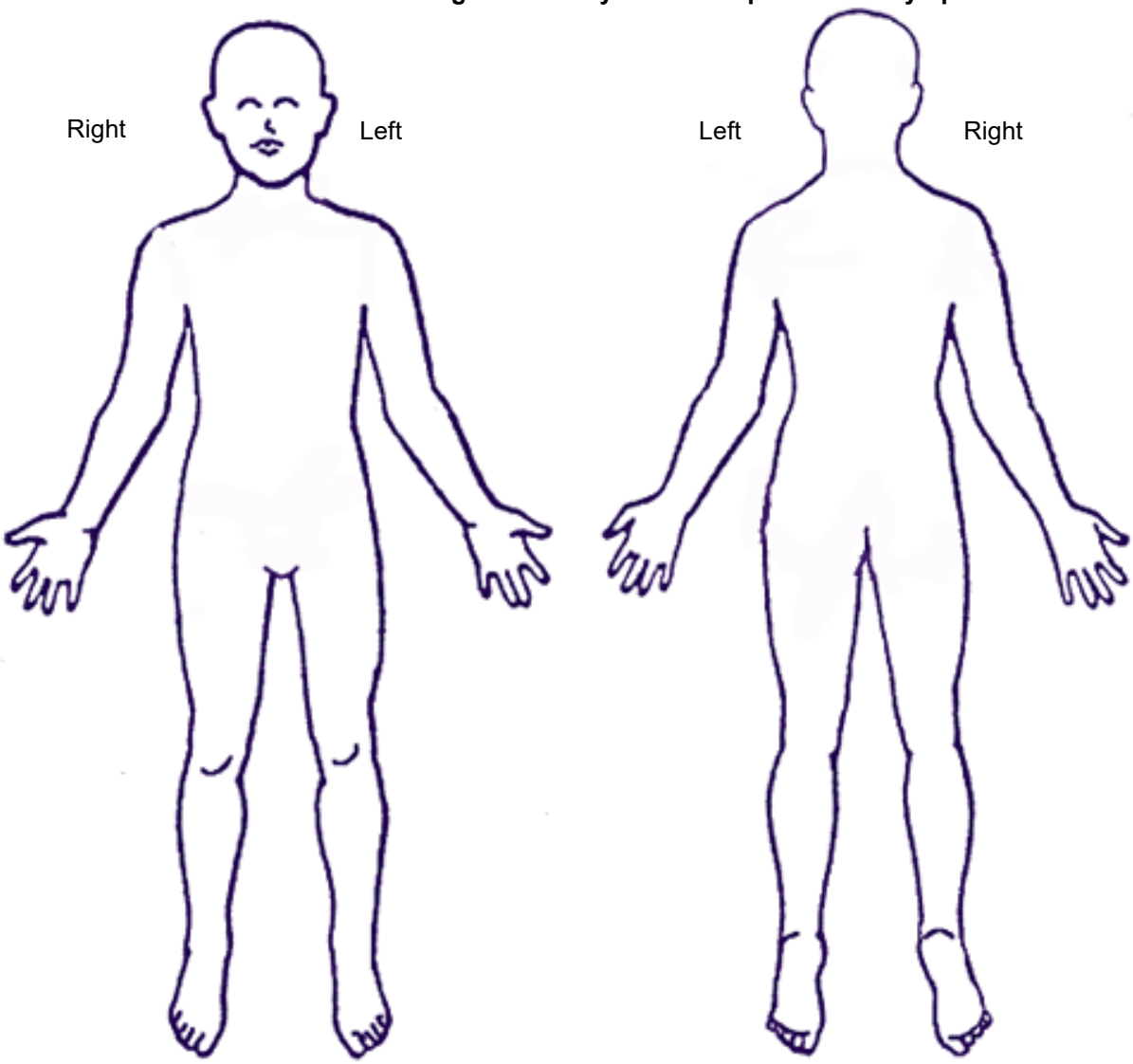
Review of Systems (Please check if any of the following apply to you)

Condition			
	Hypertension		Neurological Disorders, i.e. strokes, seizures
	High Cholesterol		Cancer
	Cardiac Disease		Eye Disease
	Respiratory Disease		Arthritis or Gout
	Bowel Problems/Disease		Diabetes
	Stomach Ulcers/Hernias		Thyroid Disease
	Liver Disease		Kidney/Bladder/Prostate Disease
	Bleeding Disorders/Anemia		Abnormal Vaginal Bleeding/GYN Disease
	Anxiety, Depression or other condition		Anesthesia Problems
	Dentures, Braces, Loose Teeth/Caps, Bridges		Have you had a flu vaccine?
	Have you had the Pneumococcal Vaccine?		Have you had a Blood Transfusion?
	Date of Blood Transfusion		Have you had a reaction to a Blood Transfusion?
	Do you have a Healthcare Proxy?		Hearing problems

NEW YORK
SPORTS & JOINTS
ORTHOPAEDIC SPECIALISTS

Patient Registration Form

Please indicate on the diagram where you feel the pain and/or symptoms:



1. **On a scale from from 0 to 5 (5 being the worst) how severe is your pain at the onset? ____**
2. **On a scale from 0 to 5 how severe is your pain today? ____**
3. **Circle how bad your pain is based on the pictures below:**

www.nysportsandjoints.com **P** (212) 355-5555 **F** (877) 992-0798

Manhattan 110 Duane Street Ground Floor, New York, NY 10007
Queens 125-10 Queens Blvd, Kew Gardens, NY 11415
Long Island 520 Franklin Ave, Suite 211, Garden City, NY 11530

4. **What is the quality of the pain?**

   Sharp Shooting Stabbing Dull Aching Intermittent Constant

   If other, please specify:_____

5. **What makes your problem worse? (Circle all that apply)**

   Standing Sitting Walking Lifting Exercise Twisting

   Lying Down Squatting Kneeling Bending Coughing Sneezing

   If other, please specify:_____

6. **What treatments have you had for this problem? (Circle all that apply)**

   Epidural Injections Physical Therapy Massage Stimulation (TEN)

   Acupuncture Trigger Point Injections Brace

   If other, please specify:_____

7. **Do you have: (Circle all that apply)**

   MRI Report/Films X-Ray Films EMG (Nerve Conduction Studies)

   CT Scans Disco Gram Bone Scan

   If other, please specify:_____

8. **What medications have you tried for this condition?** _____

** All information must be filled out before seeing the Doctor **

I assign directly to McCulloch Orthopaedic Surgical Services, PLLC all medical insurance and health benefits. I understand that in the event that the services rendered are not covered, or if invalid, that I am responsible for any amount not covered by the insurance carrier.

I authorize the holder of medical information about me, to be released to the NY State Worker's Compensation Board, or any information needed to determine these benefits payable for related services.

_____
Patient's Name

_____
Patient's Signature

_____
Date

Notice of Privacy Practice Policies

McCulloch Orthopaedic Surgical Services, PLLC dba New York Sports & Joints Orthopaedic Specialists, PLLC is committed to protecting the privacy of its patients. It is the intent of the above entity to comply with the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable New York State Law. The office of McCulloch Orthopaedic Surgical Services, PLLC dba New York Sports & Joints Orthopaedic Specialists, PLLC:

1. Makes its Notice of Privacy Practices available upon request to any person.
2. Provides the Notice in person no later than the date of the first service delivery after October 9, 2008.
3. Makes the Notice available at the office, for individuals to take with them upon request.
4. Posts the Notice in a clear and prominent location where it is reasonable to expect the individual receiving service to read the notice.

By signing below, I hereby acknowledge they the full privacy policy has been made available to me and will continue to be upon my request.

_____
Patient's Name

_____
Patient Signature/Date

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

Patient Registration Form

McCulloch Orthopaedic Surgical Services, P.L.L.C

Disclosure of Physician Ownership

New York: This notice is provided to you pursuant to the New York Public Health Law § 238-d. Practitioner disclosure requirements, and any other state and/or federal laws and regulations which may apply. New York state passed a law due to concerns that there may be a conflict of interest where a health practitioner makes a referral to a health care provider for the furnishing of any health related items or services where such practitioner (or immediate family member of such practitioner) has a financial relationship with or a financial interest in the health care provider. With certain exceptions, such referrals may be prohibited. The financial relationship must be disclosed to the patient as a condition to the referral. The patient must also be advised of his/her right to utilize a specifically identified alternative health care provider if any such alternative is reasonably available.

New Jersey: This notice is provided to you pursuant to section 3 of P.L. 1989, c.19 (C.45:9-22.6) and New Jersey Statutes Title 45 – 45:9-22.6 – Written disclosure form, and any other state and/or federal laws and regulations which may apply. Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, the state of New Jersey passed a law which prohibits physicians, with certain exceptions, from referring patient to a facility in which the physician (or any of his/her immediate family members) have a financial interest. The referral can be made under the condition that the physician must disclose this financial interest to patients and advise them of alternative places where they may go to obtain these services. These disclosures are intended to help patient's make a fully informed decision about their health care.

I acknowledge that I have been placed on a specific notice that Dr. Kenneth McCulloch, employee of McCulloch Orthopedic Surgical Services, PL.L.C., has a financial and ownership interest in the New Horizon Surgical Center, LLC., Fifth Avenue Surgical Center, LLC. And Surgicore Surgical Center, L.L.C. Dr. Mark Bursztyn, employee of McCulloch Orthopedic Surgical Services, PL.L.C., has a financial interest in All City Family Healthcare Center L.L.C. I have been informed that I have a right to be treated at a different facility of my own choosing if I so desire.

Additional Notice to New York No-Fault Patients Scheduled for Procedures to be performed at New Horizon Surgical Center, LLC. Or Surgicore Surgical Center, L.L.C:

Under a basic New York automobile insurance policy, an injured party is entitled to fifty thousand ($50,000.00) dollars in personal injury protection ("PIP") benefits. If, however, the applicable automobile insurance policy provides for optional lines of coverage, such as Additional PIP or Optional Basis Economic Loss ("OBEL"), the PIP benefit limit may be raised from fifty thousand ($50,000.00) dollars to one hundred thousand ($100,000.00) dollars, or more. Pursuant to 11 N.Y.C.R.R. §68.6 ("Regulation 83"), when a health service is performed outside New York State, the permissible charge for such service, shall be the prevailing fee in the geographic location of the medical provider. If you are scheduled to have a medical procedure performed at New Horizon Surgical Center, LLC. or Surgicore Surgical Center, L.L.C please take notice that these facilities are located in New Jersey. As such, the prevailing fees associated with performing your upcoming procedure may be higher than if it were performed in New York State. While it is our intention to first seek payment form your no-fault insurer, under the assignment of benefits previously provided, should the cumulative cost of your medical care exceed your policy benefits, there is a possibility that payment may need to be sought from alternate sources, including but not limited to any secondary insurance coverage that you may have or from the proceeds of your personal injury action, Should you have any questions or require further information, please do not hesitate to ask a member of our staff.

Patient Registration Form

I have read the above disclosure and additional notice. After being fully informed of the above facts and rights, of my own volition, I expressly elect to have the procedure performed at one of the above-listed centers. Any questions I may have had regarding this notice have been fully answered.

_____
Patient's Name

_____
Patient's Signature

_____
Date

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

Patient Registration Form

No-Fault/Lien Cases Only

Lien Agreement

I hereby authorize and direct you, my attorney, or Insurance company to pay directly to Russell Warren, M.D., such sums as may be due and owing him/her for Orthopaedic services rendered to me both by reason of this accident and by reason of any other bills that are due his/her office and withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect and fully compensate said Doctor.

I hereby further give Lien on my case to said Doctor against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my attorney or myself, as a result of the injuries for which I have been treated or injuries in connections therewith. I fully understand that I am directly and fully responsible to said Doctor for all medical bills submitted by him/her for service rendered to me and that this agreement is made solely for said Doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee. I also fully understand that if payment is not made as agreed upon I shall be responsible for any and all interest (**at 1.75% per month or 21% per annum**). All reasonable attorney fees, cost of collection and court cost incurred, in efforts to enforce this agreement. I hereby authorize my attorney to release *ultimate settlement figures, final disbursement and/or copy of settlement check* regarding my accident/injuries to ***McCulloch Orthopaedic Surgical Services, PLLC.***

I agree to promptly notify said Doctor on any charge or addition of *Attorney*(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added Attorney(s).

Please acknowledge this letter by signing below and returning it to the Doctor's office. I have been advised that if my Attorney does not wish to cooperate in protecting the Doctor's interest, the Doctor will not await payment but may declare the entire balance due payable.

I _____, benefit in this matter agree that I will attempt the independent medical exam that are scheduled by the insurance carrier as required by the terms of the insurance contract, in order to preserve the doctors ability to collect the medical billing. I understand that if I don't attend the scheduled independent medical exam(s) I will be responsible for all medical bills outstanding as a result of said failure. Said Responsibility is in the form of billing to myself and for a Lien.

_____	_____
Patient's Name	Attorney Name
_____	_____
Patient's Signature	Attorney Signature
_____	_____
Date	Date

Workers Compensation Only

Authorization, Assignment, and Fee Agreement

In considering the amount of medical expenses to be incurred, I, the undersigned, hereby assign and convey directly to McCulloch Orthopaedic Surgical Services, PLLC dba New York Sports & Joints Orthopaedic Specialist PLLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such Doctor. If I have, and do not pursue a Worker's Compensation Claim, or is payment and benefit(s) under this type of claim is denied for any reason other than providers fees not meeting the applicable schedule, I understand that I am responsible for any amount not covered by insurance benefits, and all reasonable legal fees spent by Provider's to collect the amount I owe. I am responsible to provide insurance information and referrals, if needed, to the Provider. Providers can submit any dispute there may be under this authorization, assignment under the American Association New York office.

_____
Patient's Name

_____
Patient Signature/Date

Private Insurance Only

Non-Participating Healthcare Waiver

Please be advised that Dr. Kenneth McCulloch, Dr. Sid Sharma, and Dr. Kevin Wright are non-participating providers of your insurance. The insurance company will not accept our assignment of benefits; therefore, all payments are sent directly to the patient.

ANY PAYMENTS RECEIVED BY YOU FROM YOUR INSURANCE COMPANY MUST BE IMMEDIATELY ENDORSED AND RETURNED TO THE SERVICING PROVIDER ALONG WITH THE EXPLANATION OF BENEFITS.

FAILURE TO DO SO MAY RESULT LATE PAYMENT, INTEREST, AND LEGAL ACTIONS.

I assume full responsibility for the entire date of service if I do not sign and return any payment received by me to the servicing provider.

_____
Patient's Name

_____
Patient's Signature

_____
Date

CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to HIPAA)

INSTRUCTIONS
To the Claimant: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers' Compensation Board, your employer's insurance carrier, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

IMPORTANT: Failure to execute this authorization may interfere with your ability to obtain workers' compensation benefits.

CLAIMANT'S NAME	CLAIMANT'S SOCIAL SECURITY NUMBER	CLAIMANT'S DATE OF BIRTH

LIST ALL WCB CASE NUMBER(S) AND CORRESPONDING DATE(S) OF ACCIDENT FOR WHICH YOU ARE GRANTING AUTHORIZATION

I, _____, hereby authorize my treating health provider,
Claimant's Name

McCulloch Orthopaedic Surgical Services, PLLC, to disclose the following described health information:
Health Provider's Name

_____

_____

_____

This information can be disclosed to the following parties: *(check all that apply; give names and addresses, if known)*

- ☒ New York State Workers' Compensation Board
- ☐ My current/former employer _____
- ☐ Workers' compensation insurance carrier(s) _____
- ☐ Third-party administrator _____
- ☒ My attorney/licensed representative _____
- ☐ The Uninsured Employer's Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)
- ☐ Special Funds Conservation Committee (for cases under Section 25-a or 15-8 of the Workers' Compensation Law)

Section 25-a: If your claim is being reopened after being previously closed, the Special Fund for Reopened Cases may be responsible for paying your medical bills and lost wage benefits.

Section 15-8: If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer's insurance carrier after a period of time has elapsed.

Redisclosure: I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.
Expiration Date: This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes.

_____ _____ _____
Printed Name of Claimant or Legal Representative | Signature of Claimant or Legal Representative | Date

If Authorization signed by a legal representative on behalf of claimant, state relationship to claimant_____and basis for authority (e.g. claimant is a minor; patient is deceased and representative is the claimant in a workers' compensation proceeding or represents the estate) _____

TO THE HEALTH PROVIDER: Keep the original of this Authorization on file. A copy must be given to the patient/claimant upon request. DO **NOT** SEND TO THE NEW YORK STATE WORKERS' COMPENSATION BOARD.

NEW YORK
SPORTS & JOINTS
ORTHOPAEDIC SPECIALISTS

New York Motor Vehicle No-Fault Insurance Law
Assignment of Benefits (AOB) Form

I, _____, ("Assignor") hereby assign to ***McCulloch Orthopaedic Surgical Service, PLLC, dba New York Sports & Joints Orthopaedic Specialists*** ("Assignee") all rights, privileges, and remedies to payment for healthcare services provided by Assignee to which I am entitled under Article 51 (the No-Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received and payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to motor vehicle accident which occurred on _____/_____/_____ (MM/DD/YY), notwithstanding any other agreement to the contrary.

This agreement may be revoked by the Assignee when the benefits are not payable based upon the Assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of a Assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS, OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THEFT, DESTRUCTION, DAMAGE, OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES, OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT EXCEEDING FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____	Theodore F. Schlegel MD
Patient's Name	Provider Name
_____	_____
Patient's Signature	Providers Signature
_____	_____
Date	Date

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
		N/A
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
New York Sports & Joints Orthopaedic Specialists, 520 Franklin Ave Ste 211, Garden City, NY 11530

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

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1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
New York Sports and Joints 125-10 Queens Blvd, Suite 9, 2nd Floor Kew Gardens, NY 11415

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Patient and Provider Social Contract

At New York Sports and Joints, we are committed to helping our patients return to their normal lives as quickly and easily as possible. The best way we can expedite your recovery is if you show up for all appointments on time and to make sure you come to the office prepared with the appropriate documents for your visit.

NYSJ does not charge a Late Cancellation or No-Show Fee; however, we do ask that you give us a 24-hour advanced notice before cancelling your appointments.

If you are running late for your appointment, we ask that you call our office at (212) 355-5555 to assure the doctor can treat you. We not only want to be respectful of the doctors' time, but the time of other patients being treated at NYSJ.

If the provider has time, you will be required to wait for the doctor to treat patients who arrived on time for their visits before the doctor can treat you. If not, we will kindly ask that you reschedule your appointment.

We also request that you help us foster a positive, healing environment for all patients. We value your insights, perspectives, and feelings. We ask that you do the same for our providers and Patient Care Team members by treating others with respect.

NYSJ does not tolerate hate or discrimination of any kind. ***If any patient speaks to NYSJ employees or other patients in a disrespectful manner, our providers have the right to reschedule the appointment to a later date. Continued disruptive behavior may result in a patient's termination from the practice.***

Thank you for entrusting NYSJ with your care. We are looking forward to working together to help you get back to doing the things you love pain and symptom free.

By signing below, you acknowledge and agree to adhere to NYSJ's Patient and Provider expectations.

Printed Name	Signature	Date