NF

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NF

Patient Demographic

Name: _____ Date: _____

Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Please Provide Your Email Address: _____

Tel.#: (Home) _____ (Cell) _____

S.S.#: _____ Age: _____ D.O.B: _____

Sex assigned at birth: ☐ Male ☐ Female Gender Identity _____ Height: _____ Weight: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Do You Have An Attorney? ☐ Yes ☐ No Attorney: _____

Attorney Tel.#: _____ Address: _____

Emergency Contact Name: _____ Tel.#: _____

Primary Care Physician's Name: _____ Tel.#: _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Name: _____ Tel.#: _____

Address: _____ City: _____ State: _____ Zip: _____

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NO FAULT INSURANCE INFORMATION

Please fill out in entirety

Insurance Carrier Name: _____

Carrier Address: _____

Carrier Telephone: _____

Adjusters Name: _____ Adjusters Phone: _____

Adjusters Fax: _____ Adjusters Email: _____

Claim #: _____ Carrier Case #: _____

Date of Injury: _____ Injured Body Parts: _____

List ALL Attorneys Representing You for ALL cases (Third Party/NF/WC etc...) _____

_____

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NEW YORK MOTOR VECHILE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM (FOR ACCIDENTS OCCURING IN AND AFTER 3/1/02)

I, _____ **("Assignor")** hereby assign Dr. Alexandre B. de Moura, Dr. Angel Macagno, Dr. Timothy Roberts, Dr. John Ventrudo, Dr. Adam Landskowsky, Dr. Joseph Hanono, Dr. Bestin Kuriakose. **("Assignor")**

All rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (No-Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not purse payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle which occurred on, not-with-standing any other agreement to the contrary.

Accident date: _____

The agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conducts of the 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 COMMERICAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY 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 TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Address of Patient) **(Date of Signature)**

Alexandre de Moura, M.D., PC, DBA
New York Spine Institute
Dr. Alexandre B. de Moura, Dr. Angel Macagno, Dr. Timothy Roberts, Dr. John Ventrudo, Dr. Joseph Hanono, Dr. Bestin Kuriakose

_____ _____
(Print name of Provider) **(Signature of Provider)**

761 MERRICK AVENUE WESTBURY, NEW YORK 11590
(Address of Provider)

_____
(Date of Signature)

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ASSIGNMENT OF RECOVERY PROCEEDS AND AUTHORIZATION TO

Patient: _____

Address: _____

Attorney: _____

I, _____, the undersigned, do hereby assign to **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, any sums due and payable, received by me or on my behalf, from any source for any and all medical treatment and or fees for services rendered to me and/or my attorney.

I authorize and direct my attorney to deduct and immediately pay **Alexandre de Moura, M.D., PC, DBA New York Spine Institute**, and such fees as may be due and payable for the assigned monies that may come into my hands or my attorney's hands in any recovery resulting from any claims or lawsuit. I further direct my attorney to contact Alexandre de Moura, M.D., PC, DBA, New York Spine Institute, to determine the exact amount owed before any money is paid to me from any recovery resulting from any claim or lawsuit. I further direct my attorney to advise **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, upon request, of the status of my lawsuits and/or any claims which may result in a monetary recovery from which the fees due and payable to **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, may be satisfied. If my attorney is replaced by another attorney, I direct that the outgoing attorney not forward my file until written acknowledgment from my new attorney is signed and forwarded to the undersigned acknowledging the terms and conditions set forth in this assignment.

Alexandre de Moura, M.D., PC, DBA, New York Spine Institute, agrees to provide reasonable cooperation in connection with securing payment for all insurance claims to the extent required by law.

In the event of any breach of this assignment by the patient and/or the patient's attorney, it is understood that the patient shall remain responsible for all legal fees required to either obtain insurance information and/or collect any monies owed to **Alexandre de Moura, M.D, PC, DBA, New York Spine Institute**, plus the expense of litigation and/or arbitration.

It is understood that this agreement, in no manner whatsoever, makes the payment of the fees due and payable to **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute** contingent upon securing a recovery in any lawsuit or in any insurance claim that I may have. I understand that I remain personally responsible for all fees for medical treatment, as well as for services rendered on my behalf to my attorney and that I am personally liable for payment of the same. Further, I acknowledge that this assignment does not, in any fashion, preclude or otherwise prevent **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, from demanding payment at any time after such services, as embraced within this assignment, are rendered.

_____

(Patient or Legal Guardian Signature)

_____

Witness

THE TERMS AND CONDITIONS OF THE FOREGOING ASSIGNMENT ARE UNDERSTOOD AND AGREED TO, BY:

Attorney: _____

Address: _____

Attorney Signature: _____ Date: _____

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MUST BE FILLED OUT IN ENTIRETY

Patient Name: _____

Date Of The Accident: _____ / _____ / _____ Occupation: _____

Employer Name and Address: : _____

Chief Complaint: _____

Where Is Pain? ☐ Neck ☐ Back ☐ Shoulder Rt/Lt ☐ Mid Back ☐ Knee Rt / Lt

How And Where Were You Injured?: _____

Describe: _____

Prior History Of Neck Or Back Pain? ☐ Yes ☐ No

Treatments You Have Received To Date: _____

☐ Physical Therapy ☐ Chiropractic Care ☐ Acupuncture
☐ Diagnostic Imaging ☐ Epidural Injections ☐ Trigger Point Injection

Are You Currently Working? ☐ Yes ☐ No ☐ Limited Duty: _____

Which State did Injury Occur: _____ , _____

Work: _____ Car Accident: _____ Other: _____

How Are You Doing? ☐ Better ☐ Worse ☐ Same

Any Other Medical Problems?: _____

Any Known Allergies?: _____

Social History:

Smoke? ☐ No ☐ Yes, How Much?: _____ Drink? ☐ No ☐ Yes, How Much?: _____

List Any Operations And/Or Hospitalizations (With Dates): _____

_____

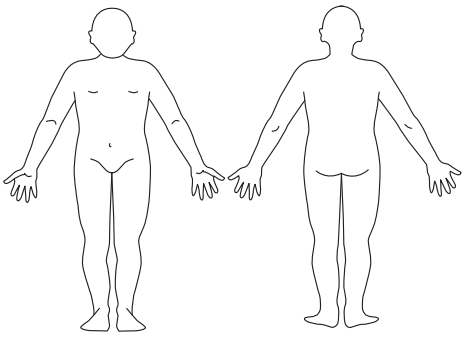
_____

Current Medications?: _____

_____

Any Radiology Testing?: _____

_____



Pain Drawing & Scale Review

NEW YORK: MANHATTAN ■ NASSAU ■ SUFFOLK ■ BROOKLYN ■ QUEENS ■ BRONX ■ WESTCHESTER ■ ORANGE
NEW JERSEY: PASSAIC ■ ESSEX

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PATIENT CONSENT FORM

Patient's Name: _____

I, the undersigned, do hereby authorize **New York Spine Institute** to provide me (or the patient-minor mentioned above) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition including, but not limited to, diagnostic X-Rays or Magnetic Resonance Imaging, Physical Therapy or Chiropractic services, the administration and/or injection of medications and pharmaceutical products, including, but not limited to tripper point injections, and the drawing of blood (the "Procedure(s)"), as in the judgment of personnel and/or physicians of **New York Spine Institute** deems necessary.

I acknowledge that no guarantees or assurances have been given to me concerning the results or findings intended from the treatment or examination at **New York Spine Institute**. I understand that the Procedure(s) and any other treatment that I may receive appear indicated by the diagnostic and/or clinical observations performed by **New York Spine**. I attest that a medical staff member of **New York Spine** has explained to me the nature of the recommended Procedure(s), the purpose of and need for the recommended Procedure(s), the possible risks and complications of the recommended Procedure(s) and the alternatives, if any, to the recommended Procedure(s). I understand all explanations given to me and give this consent voluntarily. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

This consent with cover every visit made by me (or the patient-minor) as long as I (or patient-minor) remain an active patient of **New York Spine Institute**.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Date

I declare that I have personally explained the above information to the patient or the patient representative.

_____ _____
Provider's Signature Date

FOR FEMALE PATIENTS ONLY:
I understand that in the course of my treatment I may have x-rays or other diagnostic tests. I agree to inform the health care providers if I am or may be pregnant prior to administering any diagnostic tests.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

Dear Patient:

We are required to provide you with a copy of our Notice of Privacy Practices which describes your rights and the Provider's legal duties with respect to the use and/or disclosure of your protected health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of **Alexandre B. De Moura, M.D., P.C. d/b/a New York Spine Institutes** of Privacy Practices which discloses my rights and the Provider's legal duties with respect to the use and/or disclosure of my protected health information

.

_____ _____

Patient/Designated Representative Signature | Print Name

_____ _____

If designated representative, relationship to patient | Date

FOR PROVIDER USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices. We were unable to obtain such acknowledgment, however, because:

- ☐ Treatment was rendered in an emergency treatment situation. Efforts will be made to obtain the acknowledgment as soon as reasonable practicable after the emergency.
- ☐ We were unable to effectively communicate with the patient: Reason:

  _____
- ☐ Patient refused to sign: Reason Given:

  _____
- ☐ Other (please specify):

  _____