COMPREHENSIVE ORTHOPEDIC & SPINE CARE

# Patient Intake

| | |
|---|---|
| Name(Nombre) : | DOB( Fecha de Nacimiento) : |
| Address (Dirección) : | |
| City(Cuidad): | Zip code(Codigo Postal): |
| Tel. number (Numero de Telefono): | |
| Email (Correo Electronico): | |
| Gender(Genero): M F | Status: Single(Soltero) Married(Casado) other: |
| Pharmacy name (Farmacia): _____ | In case of emergency (en caso de emergencia): |
| Address(Dirrecion): _____ | Name & relationship (Nombre) : _____ |
| Tel No.(Numero): | Tel No.(Numero) |
| Family Doctor (doctor primario): | Referred by (Referencia): |

**Commercial/Private Insurance:**

| |
|---|
| Insurance company (Seguro medico): |
| Policy Number (Numero de Póliza ): |
| ID number (Numero de ID): |
| Policy holder name (Nombre del titular de la Póliza): ☐ Same as above (Lo Mismo Que Arriba) ☐ Other: |
| If the patient isn't the policy holder, indicate relationship (Si el paciente no es el titular de la póliza, indique la relación): Spouse (Esposo/a) Child (hijo/hija) Other: |
| Policy Holder's DOB (Fecha de Nacimiento del titular de la póliza) |

**Worker's Compensation/ Motor Vehicle Accident Patients: ONLY**

| | |
|---|---|
| Insurance company (Compania) | |
| Address (Dirección) | |
| Adjuster's name (Nombre de Ajustador) | |
| Tel No. (Numero) | |
| Claim # (Numero de Reclamo) | |
| Date of accident (Dia de Accidente) | |
| Employer (Empleador) | |
| Employer's address (Dirección de Empleador) | |

**Attorney Information (Información del abogado):**

| | |
|---|---|
| Name (Nombre) | |
| Address (Dirección) | |
| Tel No. (Numero de Telefono) | |

Comprehensive Orthopedic and Spine Care does not participate in all Commercial Insurances, however we will submit all claims to your insurance carrier if your carrier accepts out-of-network claims. We only accept as payment the allowed amount under the Assignee's insurance plan and we do not bill for uncovered charges. *Comprehensive Orthopedic and Spine Care no participa en todos los seguros comerciales, sin embargo, presentaremos todos los reclamos a su compañía de seguros; para ver si su compañía acepta reclamos afuera de la red. Solo aceptamos como pago la cantidad permitida bajo el plan de seguro del Cesionario y no facturamos por cargos no cubiertos.*

Signature _____ Date: _____

**Insurance Assignment and Release**

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to COSC, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay. (Certifico que la información que he reportado con respecto a la cobertura de mi seguro es correcta. También autorizo la divulgación de cualquier información médica necesaria para procesar este reclamo. También autorizo el pago de beneficios médicos a COSC, por los servicios de anestesia y cirugía ortopédica que me brinden. Entiendo completamente que el pago de los servicios no depende de la recuperación y esto no me exime de mi obligación principal de pagar.)

Signature _____ Date: _____

**Medicare Patients ONLY**

In Medicare cases, COSC agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.(En los casos de Medicare, COSC acuerda aceptar la determinación del cargo de Medicare como el cargo total, y el paciente es responsable únicamente por el deducible, el coseguro y los servicios no cubiertos. El coseguro y los deducibles se basan en la determinación de cargos de Medicare.)

Signature _____ Date: _____

COMPREHENSIVE ORTHOPEDIC & SPINE CARE™

Name(Nombre):_____
DOB (Fecha de Nacimiento):_____

## Medical History (Historial medico)

Age(Edad): _____ Height(Altura):_____ Weight(Peso):_____

Why are you seeing the doctor today? ¿Por qué estás viendo al doctor hoy?_____

Date of Injury/Onset of Problem (Fecha de la lesión / aparición del problema):_____

Current problem is a result of (El problema actual es el resultado de):

Car Accident / Accidente automovilístico — Work Accident / Accidente laboral — Other / Otro

### Medications (Medicamentos):

| Medication Name (Nombre de la medicación) | Reason (Razón) |
|---|---|
| | |
| | |
| | |
| | |

### Allergies (Alergias):

| Allergy to (Alergia a) | Reaction (Reacción) |
|---|---|
| | |
| | |

☐ No known drug allergies (Ningun alergia a medicamentos)

**Do you, or your family have any of the following? ¿Tiene usted o su familia alguno de los siguientes?**

| | | | |
|---|---|---|---|
| Diabetes (Diabetes) | Y | N | FAMILY |
| Heart Trouble (Problemas del corazón) | Y | N | FAMILY |
| Epilepsy (Epilepsia) | Y | N | FAMILY |
| High blood pressure(Alta presión) | Y | N | FAMILY |
| DVT/Blood Clots(TVP/coágulos de sangre) | Y | N | FAMILY |
| Circulation problems(Problemas de circulacion) | Y | N | FAMILY |
| Osteoprosis (Osteoprosis) | Y | N | FAMILY |
| Arthitis (Artitis) | Y | N | FAMILY |
| Bowel/Bladder Problem | Y | N | FAMILY |
| AIDS/HIV (SIDA / VIH) | Y | N | FAMILY |
| Cancer (Cáncer) | Y | N | FAMILY |

If so, Type(Que Tipo):_____

| | | | |
|---|---|---|---|
| Bleeding Disorder (Desorden de sangre) | Y | N | FAMILY |
| Stroke/TA | Y | N | FAMILY |
| Alzhemir's (Alzhemir) | Y | N | FAMILY |
| Hepatitis (Hepatitis) | Y | N | FAMILY |

Any other issue(cualquier otro problema):_____

Are you/could you be pregnant? ¿Estás o podrías estar embarazada?

Y N

## Social History (Historial social)

Do you smoke or chew tobacco? ¿Fuma o mastica tabaco?

Y N

Do you drink alcholic beverages? ¿Bebes bebidas alcohólicas?

Y N

Do you use recreational drugs? ¿Usa drogas recreativas?

Y N

**Have you had any previous surgeries?¿Ha tenido cirugías previas?**

| Surgery type (Tipo de cirugia) | When? |
|---|---|
| | |
| | |

## Review of Systems (check if you experience symptoms)
## Revisión de sistemas (verifique si experimenta síntomas)

**GENERAL**
- ☐ Fever (Fiebre)
- ☐ Weight change(Cambio de peso)
- ☐ Hormonal
- ☐ Other
- ☐ NONE

**CARDIOVASCULAR**
- ☐ Chest pain (Dolor de pecho)
- ☐ Palpitations (Palpitaciones)
- ☐ Fluid/Swelling in extremities (Líquido/hinchazón en las extremidades)
- ☐ Other
- ☐ NONE

**KIDNEY/BLADDER**
- ☐ Painful urination (Dolor al orinar)
- ☐ Frequent urination (urinación frequente)
- ☐ Incontinence (Incontinencia)
- ☐ Other
- ☐ NONE

**EYES (OJOS)**
- ☐ Glasses/Contacts (Gafas/Contactos)
- ☐ Cataracts (Cataratas)
- ☐ Glaucoma
- ☐ Other
- ☐ NONE

**RESPIRATORY(RESPIRATORIO)**
- ☐ Shortness of Breath (Dificultad para respirar)
- ☐ Sleep apneas(Apneas del sueño)
- ☐ Wheezing (sibilancies)
- ☐ Other
- ☐ NONE

**ENT**
- ☐ Difficulty swallowing(Dificultad para tragar)
- ☐ Ear pain (Dolor de oído)
- ☐ Seasonal allergies (Alergias Estacionales)
- ☐ Hard of hearing (Problemas de Audición)
- ☐ Other
- ☐ NONE

**GASTROINTESTINAL**
- ☐ Heartburn (Acidez)
- ☐ Diarrhea/Constipation (Diarrea / estreñimiento)
- ☐ Nausea/Vomiting (Náuseas / vómitos)
- ☐ Abdominal pain(Dolor abdominal)
- ☐ Other
- ☐ NONE

**SKIN**
- ☐ Rashes (sarpullido)
- ☐ Lumps (bultos)
- ☐ Other
- ☐ NONE

**HEMATOLOGY / LYMPHATIC**
**HEMATOLOGÍA / LINFÁTICO**
- ☐ Anemia
- ☐ Blood problems (problemas de sangre)
- ☐ Clotting disorder (Trastorno de la coagulación)
- ☐ Lymph problems (Problemas linfáticos)
- ☐ Other
- ☐ NONE

**NEUROLOGICAL**
- ☐ Headaches (dolor de cabeza)
- ☐ Numbness (entumecido)
- ☐ Tingling (Hormigueo)
- ☐ Seizures (Convulsiones)
- ☐ Weakness (Debilidad)
- ☐ Other
- ☐ NONE

**PSYCHOLOGICAL**
- ☐ Anxiety (Ansiedad)
- ☐ Depression (Depresión)
- ☐ Mood Swings (Cambios de humor)
- ☐ Other
- ☐ NONE

To the best of my knowledge, the above information is complete and correct. Understand that it is my responsibility to inform my doctor if I ever have a change in health. (Certifico que la información que he reportado con respect a salud es correcta.Entiendo que es mi responsabilidad informar a mi médico si alguna vez tengo un cambio de salud.)

Signature_____

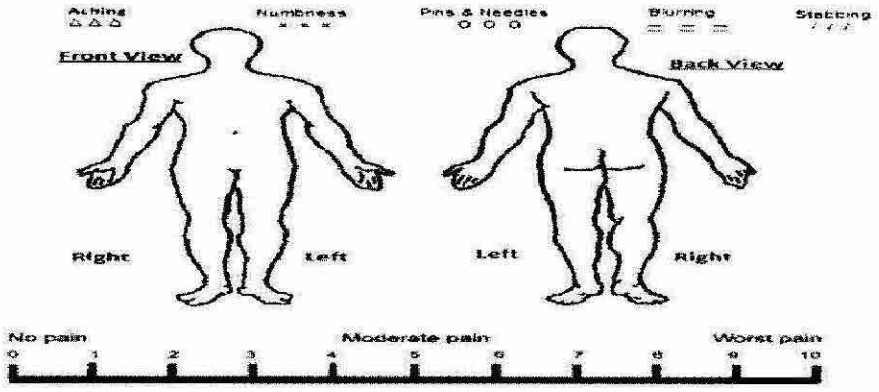
Date_____

COMPREHENSIVE
ORTHOPEDIC & SPINE CARE™

Name(Nombre):_____
DOB (Fecha de Nacimiento):_____

# New Problem Questionnaire (Cuestionario de problemas nuevos)

1. What is your main problem? ¿Cuál es su principal problema?
   - ☐ Pain (Dolor)
   - ☐ Numbness (Entumecimiento)
   - ☐ Weakness (Debilidad)
   - ☐ Stiffness (Rigidez)
   - ☐ Unstable or Dislocating Joint (Articulación Inestable o Dislocada)
   - ☐ Swelling (Hinchazón)
   - ☐ Other:_____
2. How did your problem start? ¿Cómo empezó su problema?
   - ☐ Work Injury (Accidente de Trabajo) Date of Accident(Fecha del accidente):_____
   - ☐ Car accident (Accidente Automovilistico)
   - ☐ Sports injury (Lesion deportiva) ☐ Suddenly (Repentinamente) ☐ Gradually (Gradualmente)
   - ☐ Other:_____
3. Does your pain awaken you from sleep? ¿Su dolor lo despierta del sueño?
   - ☐ Yes ☐ No
4. Is your pain intermittent or constant? ¿Su dolor es intermitente o constante?
   - ☐ Intermittent ☐ Constant
5. What worsens your problem? ¿Qué empeora su problema?
   - ☐ Exercise (Ejercicio)
   - ☐ Sitting (Sentarse)
   - ☐ Standing (Estar de Pie)
   - ☐ Rest (Descansar)
   - ☐ Nothing (nada)
   - ☐ Repetitive Motions (Movimientos repetitivos)
   - ☐ Overhead Activities (Actividades generals)
   - ☐ Coughing, Sneezing, Straining (Toser, estornudar, hacer esfuerzos)
   - ☐ Walking (Caminar)
   - ☐ Other: _____
6. What helps your pain? ¿Qué ayuda a aliviar su dolor?
   - ☐ Rest (Descansar) ☐ Nothing (Nada) ☐ Other:_____
7. Are your regular activities limited specifically because of your problem? ¿Están limitadas sus actividades habituales específicamente debido a su problema?
   - ☐ No ☐ Yes (Give details/ Dar detalles):_____
8. Have you had this problem before? ¿Ha tenido este problema antes? ☐ No ☐ Yes When (Cuando) _____
9. Have you had previous medical treatment for this? ¿Ha tenido tratamiento médico anteriormente por esto?
   - ☐ None (Ninguno)
   - ☐ Emergency room (Sala de emergencias)
   - ☐ Surgery (Cirugía)_____
   - ☐ Other_____
   - ☐ Injection (Inyección)_____
   - ☐ Physical therapy (Terapia física)_____
   - ☐ Physician (Medico)_____
10. What tests have you had? ¿Qué examenes te has hecho?
    - ☐ X-Rays ☐ CT scan ☐ MRI ☐ EMG ☐ Ultrasound
11. Are you currently working? ¿Estás trabajando actualmente?
    - ☐ Not working Date last worked (Ultimo dia de Trabajo)
    - ☐ Light duty (Trabajo ligero) ☐ Regular job ( Trabajo regular)
12. Please mark the areas on your body where you feel pain. Also, rate your pain on scale. (Marque las áreas de su cuerpo donde siente dolor. Además, califique su dolor en la escala.)




To the best of my knowledge, the informnation above is complete and correct.(Certifico que la información que he reportado es completa y correcta)

Signature:_____ Date:_____

COMPREHENSIVE
ORTHOPEDIC & SPINE CARE™

# COVID-19 INFORMED CONSENT

I understand I am giving this informed consent to Joseph Weinstein,D.O., P.C. d/b/a Comprehensive Orthopedic & Spine Care (the practice) evidencing my eduated decision to receive services at the practice prior to any known effective treatment to the CoronaVirus-COVID-19. I have been advised that the pratice has adopted recommended protocols for the prevention of COVID-19 at it's facility. I have been advised I can request additional information prior to signing this consent, and at any time thereafter, as to the specific protocols in place regarding the practice response to COVID-19.

By signing below, I acknowledge my understanding that the COVID-19 virus has a period during which carriers of the virus may not show symptoms and may still be highly contagious. I understand the practice will be treating patients other than myself at its facility, as well as employing personnel who may be asymptomatic or qualifed as "recovered" in accorance with CDC guidelines. I understand that it is impossible to determine who has it and who does not, at any given time. I understand it is my responbility to notify the practice if I am medically "high risk" for any reason.

By signing below, I hereby agree to release the practice, and its owners, members, officers, employees, contractors, agents, and representatives (practice representatives) and not to commence or maintain any action or proceeding against any practice representative, for or from any and all claims, causes of action, liabilities, damages, fees (including attorney fees and costs of defense) and demands whatsoever, in law or equity (claims), which I (and my heirs, executors, administrators and assigns) shall or may have, or from any person or entity other than myself, for , upon, or by reason of my contracting COVID-19, including any claim resulting from my transmission of COVID-19 to any other person or thing. I hereby agree to indemnify and hold the practice representatives harmless from and against any and all claims from or against any person or entity other than myself relating to my having or transitting COVID-19.

By signing below, I acknowledge I have read this informed consent and I hereby agree to its terms and I assume the risk of potiental COVID-19 exposure by receiving treatment at the practice.

Patient Name (Nombre): _____

Patient Signature (Firma):_____ Date (Fecha):_____

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 (NOMBRE DE PACIENTE) | Date of Birth (FECHA DE NACIMIENTO) | Social Security Number |
|---|---|---|
| Patient Address (DIRECCION DE PACIENTE) | | |

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:

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

**COMPREHENSIVE ORTHOPEDIC & SPINE CARE 62-54 97th Place Rego Park NY 11374 T.718-313-0766 F.347-507-5553**

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: | 11. Date or event on which this authorization will expire: |
|---|---|
| ☑ At request of individual<br>❑ Other: | **END OF CARE** |
| 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.**

COMPREHENSIVE
ORTHOPEDIC & SPINE CARE™

# WORKER'S COMPENSATION INFORMATION (INFORMACIÓN DE COMPENSACIÓN)

Description of how injury occurred (Descripción de cómo ocurrió la lesion):_____

_____

_____

Any Previous WC Injuries (Alguna lesion previa) YES OR NO

On the date of injury, what were the usual work activities (En la fecha de la lesión, ¿cuáles eran las actividades laborales ?)_____

_____

What is the patients job title (¿Cuál es el puesto de trabajo del paciente?)_____

Have you missed work because of the injury's? (¿Ha faltado al trabajo debido a la lesión?) NO YES

If YES, what was the first missed day of work? (Si su repuesta es si, cual es el primer dia que faltó al trabajo) _____

Are you currently working? (Estas trabajando?) YES NO

I (Yo)_____ am being treated by Dr. Joseph Weinstein and I give permission to release office medical records (estoy siendo tratado por el Dr. Joseph Weinstein y doy permiso para mis registros medicos cuando sea nesecario)

I (Yo)_____ have read a copy of Dr. Joseph Weinstein's Notice of Privacy Practice. (He leído una copia del Aviso de privacidad del Dr. Joseph Weinstein.)

In the event I fail to prosecute the claim for Workers Compensation for this illness or condition or it is determined by the Workers Compensation Board that the illness or condition is not a result of a compensable case, I hearby agree to pay Dr. Joseph Weinstein at 62-54 97th Place Rego Park NY, 11374 his usual and customary fees for services rendered to the above named claimant. (En el caso de que no procese el reclamo de Compensación por esta enfermedad o condición o si la Junta de Compensación determina que la enfermedad o condición no es el resultado de un caso indemnizable, acepto pagarle al Dr. Joseph Weinstein en 62-54 97th Place Rego Park NY, 11374 su tarifa por los servicios prestados al reclamante mencionado anteriormente.)

_____ _____

Signature of Patient or Authorized Person Date

# NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

| WCB CASE NO. (If Known) | CARRIER CASE NO. (If Known) NUMERO DE RECLAMO | DATE OF INJURY FECHA DE ACCIDENTE | NATURE OF INJURY OR ILLNESS | INJURED PERSON'S SOC. SEC. NO. |
|---|---|---|---|---|
| | | | | |

| | | | |
|---|---|---|---|
| CLAIMANT | NAME NOMBRE | ADDRESS DIRRECION | APT. NO. |
| EMPLOYER | | | |
| INSURANCE CARRIER | | | |

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below 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 occurs, 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.

Claimant's Signature _____ Date _____
FIRMA DE PACIENTE

Provider's Name and Address COMPREHENSIVE ORTHOPEDIC & SPINE CARE {Dr. Joseph Weinstein}

62-54 97th Place Ste.2C Rego Park, NY 11374 T.718-313-0766 F.347-507-5553

**TO THE CLAIMANT**

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

**Workers' Compensation Law Section 32**

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

**TO THE HEALTH CARE PROVIDER**

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.