

# LONG ISLAND NEUROSURGICAL & SPINAL ASSOCIATES

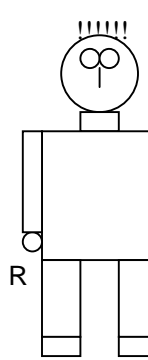
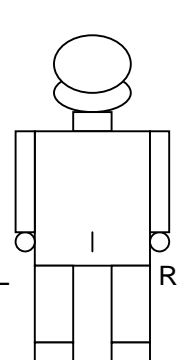
## PATIENT CLINICAL INFORMATION SHEET – Form 1A

*Please print clearly*

Patient Name	_____	Age	_____	Date	_____
	Last Name	First Name	M.I.	Date of Birth	
Referred by:					<input type="checkbox"/> Male
Physician	_____				<input type="checkbox"/> Female
Other	_____				
	Primary Care Physician				_____

### HEALTH INFORMATION

*Please check all items that apply*

<input type="checkbox"/> R / L Handed (Please circle) <input type="checkbox"/> Operations: _____ _____ <input type="checkbox"/> <b>Drug Allergy:</b> _____ _____ _____	<b>Do you smoke:</b> yes/no <b>Do you use alcohol:</b> yes/no Recent weight loss: yes/no How much: _____ lbs	<input type="checkbox"/> <b>Medications:</b> _____ <input type="checkbox"/> <b>Other: (Include non-prescription drugs):</b> _____ _____ _____ _____	<b>ASA:</b> yes/no <b>Plavix:</b> yes/no <b>Coumadin:</b> yes/no
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> <b>Heart Disease:</b> <input type="checkbox"/> Angina/Chest Pain <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Heart Failure <input type="checkbox"/> Pace Maker <input type="checkbox"/> Valve Disease <input type="checkbox"/> <b>Respiratory Disease:</b> <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Recent Infection <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> <b>Intestinal Disorders:</b> <input type="checkbox"/> Ulcers <input type="checkbox"/> Hiatus Hernia	<input type="checkbox"/> Colitis/Diverticulitis <input type="checkbox"/> Blood in Stool <input type="checkbox"/> <b>Blood Disorders:</b> <input type="checkbox"/> Blood Clotting Problems <input type="checkbox"/> Anemia <input type="checkbox"/> Immune Deficiency <input type="checkbox"/> Low White Cell Count <input type="checkbox"/> Severe Bleeding after Dental/Surg or Trauma <input type="checkbox"/> <b>Liver Disease:</b> <input type="checkbox"/> Hepatitis <input type="checkbox"/> Yellow Jaundice <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> <b>Kidney Disease:</b> <input type="checkbox"/> Dialysis/Failure <input type="checkbox"/> Infection <input type="checkbox"/> Stones <input type="checkbox"/> Blood in Urine <input type="checkbox"/> <b>Endocrine Disorders:</b> <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Adrenal Disease	<input type="checkbox"/> Pituitary Disease <input type="checkbox"/> <b>Arthritis:</b> <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Lupus <input type="checkbox"/> <b>Infectious Disease:</b> <input type="checkbox"/> Lyme's Disease <input type="checkbox"/> Other <input type="checkbox"/> <b>Neurological:</b> <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Headaches <input type="checkbox"/> Bladder Problems <input type="checkbox"/> Walking Problems <input type="checkbox"/> Visual Problems <input type="checkbox"/> <b>Malignant Hyperthermia</b> Other: _____ _____	<input type="checkbox"/> <b>Pain:</b> <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Arm <input type="checkbox"/> Leg  <p style="text-align: center;"><b>Indicate location of Pain on Diagrams</b></p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <p style="text-align: center;">Front                      Back</p> <p style="text-align: center;"><b>Pain Scale (0 – 10):</b> _____</p>

### NURSES NOTES

Weight	Height	BP	Reviewed by:
_____	_____	_____	_____
Other	Pulse		
_____	_____	_____	_____

**LONG ISLAND NEUROSURGICAL & SPINAL ASSOCIATES**

**Insurance Form – Form 1B**

*Please print clearly*

Patient Name \_\_\_\_\_ Soc.Sec# \_\_\_\_\_  
Last name First name MI  
Home Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Marital status:  Married  Single  Divorced  
 Widowed  Minor  
Telephone (\_\_\_\_) \_\_\_\_\_ Occupation \_\_\_\_\_  
Home (\_\_\_\_) \_\_\_\_\_ Spouse name \_\_\_\_\_  
Work  
Employer/School \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Insurance Company Name \_\_\_\_\_  
Name of Subscriber \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**OTHER INSURANCE**

Insurance Company Name \_\_\_\_\_  
Name of Subscriber \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Type of Case:**  Workers Compensation  No-Fault  School Injury  Other Liability  
Date of Injury \_\_\_\_\_ Location \_\_\_\_\_ Nature of Injury \_\_\_\_\_  
Are you pursuing legal action?  Yes  No

**Medicare Patients:** Is this MEDIGAP  Yes  No  
Do you require a referral:  Yes  No Co-Payment/Deductible  Yes  No Amount \$ \_\_\_\_\_

**ASSIGNMENT OF BENEFITS/AUTHORITY FOR RELEASE OF INFORMATION**

I irrevocably assign/authorize Drs. Ira & Marc Chernoff and Dr. P. Arjen Keuskamp the following:

- A) All my rights and benefits under Medicare or Insurance Contracts for payment of services rendered to me by them;
- B) That all information regarding my benefits under any insurance policy relating to claims to be released to them;
- C) To file insurance claims on my behalf including Medigap, if applicable, for services rendered to me;
- D) That all such payments go directly to them;
- E) To act on my behalf and report any suspected violations of proper claim practices to the proper regulatory authorities;
- F) The provider to release any information necessary to substantiate a claim.

If this is a private insurance claim, I agree to be responsible for the full amount of the charges from the date of delivery if my private insurance company does not pay for charges in a timely manner, or I fail to provide within thirty (30) days the information necessary to submit the claim for payment. Any questions I may have concerning this assignment of benefits have been explained to my full satisfaction, and I understand it's nature and effect.

X \_\_\_\_\_ Date \_\_\_\_\_  
Beneficiary (or Parent/Guardian) Relationship

X \_\_\_\_\_ Date \_\_\_\_\_  
Representative (If patient is unable to sign) Relationship

# LONG ISLAND NEUROSURGICAL & SPINAL ASSOCIATES

## Patient Contact Information – Form 1C

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

### I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

*(Please check all items that apply)*

<input type="checkbox"/> Home Telephone _____ <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Written Communications: <input type="checkbox"/> O.K. to mail to my home address <input type="checkbox"/> O.K. to mail to my work/office address <input type="checkbox"/> O.K. to fax to this number:
<input type="checkbox"/> Work Telephone _____ <input type="checkbox"/> O.K. to leave message with detailed information <input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Fax Number _____

In case of communications about your PHI (case history, treatment and progress) to third parties, such as relatives and friends, we will protect your right to privacy by providing information only to those individuals specifically designated by you.

### THIRD PARTY CONTACTS

*(Please List Below)*

The <u>primary</u> person I wish to have access to information in regard to my medical condition is:	
Name _____	Relationship _____
Street Address _____	
Town/State/Zip Code _____	
Telephone Number _____	
The <u>alternate</u> person I wish to have access to information in regard to my medical condition is:	
Name _____	Relationship _____
Street Address _____	
Town/State/Zip Code _____	
Telephone Number _____	

I have read and understand the above information and acknowledge that these directions are considered in effect until I notify Long Island Neurosurgical & Spinal Associates in writing about any change.

Your Name \_\_\_\_\_

Your Signature **X** \_\_\_\_\_

Date \_\_\_\_\_

# LONG ISLAND NEUROSURGICAL & SPINAL ASSOCIATES

## Notice of privacy for Patient's Protected Health Information – Form 1D

This is a summary describing how health care information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. A full description is available on request.

This office abides by the terms described in this policy.

### **This office may use and disclose your Protected Health Information (PHI) without your specific authorization for the following reasons:**

- To share information with other treating health care providers regarding your health care.
- To obtain payment for rendered services by submitting claims to insurance companies, Workers Compensation, Medicare,
- HMOs and other health care plans.
- To determine patient's benefits in a health care plan.
- To release information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- To enable business activities with associates from whom written assurances to protect your privacy has been obtained.
- To support and improve our health care operations by comparing patient data.
- In emergency situations and Funeral arrangements.
- In cases of abuse, neglect or domestic violence.
- For Public Health purposes, Health Oversight audits or inspections.
- When required by law in specific circumstances, such as valid orders from Law Enforcement Agencies, Judicial or Administrative bodies.
- In response to requests from Disaster Relief Authorities for the purposes of notification of next of kin.
- To communicate appointment reminders to household members or answering machines, as designated in your authorized contact information.
- To verify office visits by disclosing sign-in logs.

### **Any other use or disclosure of your PHI will only be made with your specific prior authorization. You have the right to:**

- Revoke authorization, in writing, at any time by specifying what information you want restricted and to whom.
- Inspect, copy and amend your protected health information as allowed by law.
- A request to correct or amend a record has to be submitted in writing and must be accompanied by its reason. Such
- correction or amendment will be entered as an addendum to the original record.
- (We may charge a fee for copying, mailing or other related supplies).
- Obtain an accounting of disclosures of your protected health information to other parties, other than for treatment, payment,
- health care operations, or specifically authorized disclosures. The request must be made in writing, state the time period
- (less than 6 years and beginning April 14, 2003). (A fee may be charged to produce this list).
- To render a written complaint to our privacy officer, the US Department of Health and Human Services or Office of Civil Rights.
- Under no circumstance will you be penalized for filing a complaint.
- Contact our office and speak to our privacy officer **Ira Chernoff, MD** at (631)246-6100 for any questions.

**This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.**

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient (Print) \_\_\_\_\_

Signature of Patient/Legal Representative **X** \_\_\_\_\_ Date \_\_\_\_\_

# LONG ISLAND NEUROSURGICAL & SPINAL ASSOCIATES

## PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: \_\_\_ / \_\_\_ / \_\_\_

I, \_\_\_\_\_ hereby authorize Long Island Neurosurgical & Spinal Associates to disclose my entire information file to: \_\_\_ Myself (I will pick up) \_\_\_ Please mail my records to my home \_\_\_ Other: \_\_\_\_\_

### SPECIFIC INFORMATION TO BE USED AND / OR DISCLOSED

\_\_\_ Office notes, x-rays, procedure notes, diagnostic reports

\_\_\_ You may discuss my medical file (Entire Health Information) with the following:

1. \_\_\_\_\_  
Name and relationship
2. \_\_\_\_\_  
Name and relationship
3. \_\_\_\_\_  
Name and relationship

### PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING AT THE BOTTOM

I understand that pursuant to this authorization any of the following confidential health information will be released:

- Any information in my records sexually transmitted disease, acquired immune deficiency syndrome (AIDS) or human immune deficiency virus (HIV). This includes HIV or AIDS related test information and related illnesses.
- Any information concerning substance abuse and/or its treatment, behavioral treatment or mental illness services, and psychiatric treatments.

I understand that:

- I have the right to revoke this authorization at any time.
- This revocation has to be done in writing and presented to the office.
- This revocation does not apply to information already released pursuant to this authorization.
- This revocation does not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless otherwise revoked, this authorization will expire in 90 days.
- Authorization of this health information is voluntary.
- I can refuse to sign this authorization.
- I need to sign this authorization in order to ensure treatment.
- I may inspect or copy information to be used or disclosed, as provided in CFR 164.524.
- Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the Federal Confidentiality Rules may not protect the information.
- If I have any questions about disclosure of my health information, I may call our main office.  
Smithtown (631)265-2020 or Stony Brook (631)246-6100

X \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ SS#: \_\_\_\_\_  
Patient Signature

X \_\_\_\_\_ X \_\_\_\_\_  
Parent/Guardian Signature Witness

# LONG ISLAND NEUROSURGICAL & SPINAL ASSOCIATES

## Medicare Authorization of Assignment of Benefits

\_\_\_\_\_  
BENEFICIARY NAME (Please print)

\_\_\_\_\_  
MEDICARE NUMBER

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### 1. **MEDICARE**

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO DR. IRA CHERNOFF, DR. MARC CHERNOFF AND DR. P. ARJEN KEUSKAMP FOR SERVICES FURNISHED TO ME BY DR. IRA CHERNOFF, DR. MARC CHERNOFF AND DR. P. ARJEN KEUSKAMP. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER HEALTH INSURANCE IS INDICATED IN ITEM #9 OF HCFA 1500 FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS, MY SIGNATURE AUTHORIZES RELEASING THE INFORMATION TO THE INSURER OR AGENCY SHOWN.

DR. IRA CHERNOFF, DR. MARC CHERNOFF AND DR. P. ARJEN KEUSKAMP ACCEPT THE CHARGE DETERMINATION TO THE MEDICARE CARRIER AS FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLES, CO-INSURANCE AND NON-COVERED SERVICES. CO-INSURANCE AND DEDUCTIBLES ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

\_\_\_\_\_  
BENEFICIARY (Signature)

\_\_\_\_\_  
DATE

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### 2. **MEDIGAP**

IF A MEDIGAP POLICY OR OTHER HEALTH INSURANCE IS INDICATED IN ITEM #9 OF THE HCFA 1500 FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS, MY SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. I REQUEST THAT PAYMENT AUTHORIZED SECONDARY INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DR. IRA CHERNOFF, DR. MARC CHERNOFF AND DR. P. ARJEN KEUSKAMP.

\_\_\_\_\_  
BENEFICIARY (Signature)

\_\_\_\_\_  
DATE

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### 3. **OTHER INSURANCE**

I HEREBY AUTHORIZE PAYMENT OF MY MEDICAL AND SURGICAL INSURANCE BENEFITS TO DR. IRA CHERNOFF, DR. MARC CHERNOFF AND DR. P. ARJEN KEUSKAMP. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE. IF CO-PAYMENTS AND/OR DEDUCTIBLES ARE DESIGNATED BY MY INSURANCE COMPANY OR HEALTH PLAN, I AGREE TO PAY THEM TO DR. IRA CHERNOFF, DR. MARC CHERNOFF AND DR. P. ARJEN KEUSKAMP. I AUTHORIZE DR. IRA CHERNOFF, DR. MARC CHERNOFF AND DR. P. ARJEN KEUSKAMP TO RELEASE ANY INFORMATION REQUIRED TO PROCESS ANY AND ALL CLAIMS FOR REIMBURSEMENT ON MY BEHALF. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

\_\_\_\_\_  
BENEFICIARY (Signature)

\_\_\_\_\_  
DATE