MANHATTAN PAIN MEDICINE, PLLC

Name_____ **Date of Birth**_____

Address_____ **City, State, Zip**_____

Home Phone _____ **Social Security #**_____

Cell Phone _____ **E-Mail**_____

Emergency Contact (Name/relation): _____ **Phone**:_____

Primary Care Physician: _____**Phone**:_____

Reason for visit: _____

Who referred you to us? _____

Do you have any medical conditions? (please list) _____

_____

Have you ever had surgery or been in the hospital? (when/what for?) _____

_____

Do you have any Drug Allergies? (please list) _____

Current Medications: (please list) _____

_____

Do any of your immediate family members have any medical condition? (please list by relation)

_____

Height: _____ **Weight**: _____

Do you smoke cigarettes? □Yes (packs/day) _____ □No, but used to □No, never

Do you drink alcohol? □Yes (#/week) _____ □No, but used to □No, never

Do you use recreational drugs? □Yes _____ □No, but used to □No, never

Describe your type of work: _____

Prior military service? (Y / N) **Level of Education**: _____

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Do you have any of the following? (Circle all that apply)

GENERAL: weakness, fatigue, fever/chills, significant weight change.

SKIN: rash, lumps, sores, itching, dryness, color change, changes in hair or nails.

HEENT: headache, head injury, dizziness, lightheadedness, vision changes, hearing problems, tinnitus, vertigo, earaches, nasal stuffiness, nasal discharge, nosebleeds, sinus trouble, dry mouth, hoarseness.

NECK: lumps, swollen lymph nodes, goiter.

BREASTS: lumps, pain or discomfort, nipple discharge.

CARDIOVASCULAR: chest pain or discomfort, palpitations, difficulty breathing, swelling.

RESPIRATORY: cough, difficulty breathing, wheezing.

GASTROINTESTINAL: trouble swallowing, heartburn, nausea, vomiting, diarrhea, rectal bleeding or tarry stools, constipation, abdominal pain.

URINARY: uncontrolled urination, urgency, burning or pain on urination, bloody urine, urinary infections, kidney stones.

GENITAL: hernias, discharge, sores.

PERIPHERAL VASCULAR: intermittent claudication, leg cramps, varicose veins, hair loss.

MUSCULOSKELETAL: joint pain/stiffness/swelling, muscle pain/stiffness, osteoporosis, fracture

NEUROLOGIC: fainting, blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tingling, tremors or other involuntary movements.

ENDOCRINE: heat or cold intolerance, excessive sweating, excessive thirst or hunger.

PSYCHIATRIC: nervousness, depression, memory change, suicidal or homicidal ideation.

Other current symptoms: _____

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature *Date*

MANHATTAN PAIN MEDICINE, PLLC

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and the providers representatives (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

I understand that Manhattan Pain Medicine, PLLC and all providers are out-of-network with my insurance.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient name (print): _____

Signature: _____ Date: _____

MANHATTAN PAIN MEDICINE, PLLC

E-MAIL MEDICAL COMMUNICATION INFORMED CONSENT

I am engaging in email communication with my physician realizing that, because there is no way to absolutely secure any electronic exchange of information, the probability of compromise of confidentiality of personal medical information is substantially increased compared to face-to-face information exchange. As such, email communication on personal medical matters should be as limited as possible and reserved for situations not practically allowing for face-to-face communication, but in which the failure to timely inform the patient or their agent on personal medical issues could significantly compromise the patient's best interests and outcome. No guarantee is made for the timely receipt of email communication, and no guarantee of response is made.

Notwithstanding the above, email communication should, as much as possible, avoid discussion of highly sensitive medical matters that could be, in the event of an information leak, deleterious personally or publicly to the patient and/or their agents. Such topics best avoided are medical disability, sexually transmitted diseases, substance abuse, psychiatric conditions, prognoses (medical outcomes), end-of-life conditions or prognostications, disclosure of demise of an individual, and any other matter that reason could suggest might result in unpredictable emotional distress or reaction in the recipient and possibly lead to behavior harmful to the recipient or others. In a word, remote communicating is a minimally controlled circumstance. Language used should be careful, deliberate, and avoid "emotionally charged" terms.

Email medical communication is a temporary convenience and intervention, not a substitute for proper face-to-face medical encounters. Habitual, ongoing use of email for communicating medical information is discouraged in the best interests of medical professionals and patients and their agents.

By signature, I indicate I have read the above content and policy of my healthcare provider and I agree to abide by the principles and spirit set forth in this document. I further understand the risks and limitations of transmission of medical information communication electronically, and so release from all and any liability my healthcare provider for any unauthorized disclosure or leak of such information inadvertently to parties outside the intended senders and recipients of such communications. I will not hold responsible the sender of medical information by email for any delays in receiving such communications and resulting harm from such delays. I am aware that when communicating from the workplace some companies consider email "at work company property", and such messages may be monitored and read by the company's officials. Furthermore, email sent to your home may be intercepted by others. Email sent to your doctor's office, though directed to a specific individual, may be read by other than the designated recipient since all incoming messages in a medical facility must be reviewed timely, including when a staff member is absent for any reason. Finally, communicating by email always exposes both parties to the risk of computer software virus invasion which can jeopardize and destroy databases and software. By signing this, I release from any liability for damage from computer viruses my healthcare providers and their staff.

I also release my healthcare provider with whom I am communicating voluntarily in medical matters by email from any adverse effects such information has on me or my agents that might have been otherwise avoided or lessened by exchange of such information in face-to-face encounters. Taking all of the above into consideration, I wish to engage in email communications regarding my personal medical information or that for which I am a responsible agent. I have had an opportunity to ask questions on all the aforementioned and provide my consent freely.

Email Address: _____

Signature: _____ Date: _____

Name (Print): _____

MANHATTAN PAIN MEDICINE, PLLC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. S 164.520

1. **Our Duties**

We are required by law to maintain the privacy of your Protected Health Information ("Protected Health Information"). We must also provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our Privacy practices in regard to Protected Health Information and make new privacy policies effective for all Protected Health Information that we maintain. We will provide you with a copy of any current privacy policy upon your written request, addressed to our Privacy Officer, at our current address.

2. **Your Complaints**

You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by sending a certified letter addressed to "Privacy Officer" at our current address, stating what Protected Health Information you believe has been used or disclosed improperly. You will not be retaliated against for making a complaint. For further information you may contact our Privacy Officer, at telephone number (646) 580-3538.

3. **Description and Examples of Uses and Disclosures of Protected Health Information**

Here are some examples of how we may use or disclose your Protected Health Information. In connection with treatment, we will**,** for example, allow a physician associated with us to use your medical history, symptoms, injuries or diseases to treat your current condition. In connection with payment, we will, for example, send your Protected Health Information to your insurer or to a federal program, such as Medicare, that pays for your treatment. This allows us to obtain payment for the services we rendered on your behalf. In connection with health care operations, we will for example, allow our auditors, consultants, or attorney's access to your Protected Health Information to determine if we billed you accurately for the services we provided to you.

4. **Uses and Disclosures Which Require Your Written Authorization**

Uses and disclosures other than those involving treatment, payment, and health care operations, as well as those described in the following sections of this Notice, will only be made by obtaining a written authorization from you. You may revoke this authorization in writing at any time, except to the extent that we have taken action in reliance upon your authorization.

5. **Uses and Disclosures Not Requiring Your Written Authorization**

The privacy regulations give us the right to use and disclose your Protected Health Information if:
(i) You are an inmate in a correctional institution; (ii) we have a direct or indirect treatment relationship with you, (iii) we are so required or authorized by law.
The purposes for which might use your Protected Health Information would be to carry out treatment, payment, and health care operations similar to those described in Paragraph I.

6. **Uses of Protected Health Information to Contact You**

We may use your Protected Health Information to contact you regarding appointment reminders or to contact you with information about treatment alternatives or other health-related benefits and Services

that, in our opinion, may be of interest to you. We may use your Protected Health Information to contact you in an effort to raise funds for our operations.

7. **Disclosures of Protected Health Information for Billing Purposes**

We may disclose your billing information to any person that calls our billing staff or agents the billing questions after we verify the identity of the person by requesting information such as your social security number or health plan number.

8. **Disclosures for Directory and Notification Purposes**

If you are incapacitated or not present at the time, we may disclose your Protected Health Information (a) for use in a facility directory, (b) to notify family or other appropriate persons your location or condition, and (e) to inform family, friends or caregivers of information relevant to their involvement in your ease or payment for your treatment. If you are present and not incapacitated. we will make the above disclosures, as well as disclose any other information to anyone you have identified, only upon your signed consent, your verbal agreement, or the reasonable belief that you would not object to such disclosure(s).

9. **Individual Rights**

(i) You may request us to restrict the uses and disclosures of your Protected Health Information , but we do not have to agree. (ii) You have the right to request that we communicate with you regarding your Protected Health Information in a confidential manner or Pursuant to an alternative means, such as by a sealed envelope rather than a postcard or by communicating to a specific phone number, or by sending mail to a specific address. We are required to accommodate all reasonable requests in this regard. (iii) You have the right to request that you be allowed to inspect and copy your Protected Health Information as long as it is kept as a designated record set, and as long as you pay in advance for the administrative time and costs hi make arrangements to have the records inspected and copied. Certain records are exempt from inspection and cannot be inspected or copied, so each request will be reviewed in accordance with the standards published in 45 C.F.R S 164.524. (iv) You have the right to amend your Protected Health Information for as long as the Protected Health Information is maintained in the designated record set. We may deny your request for an amendment if the Protected Health Information was not created by us, or is not part of the designated record set, or would not be available for inspection as described under section 45 C.F.R. S 164.524, or if the Protected Health Information is already accurate and complete without regard to the amendment. (v) You have the right to request, and thereafter receive an accounting of the disclosures of your Protected Health Information for six years before the date on which you request the accounting. Exceptions to this accounting are those disclosures not allowed by law pursuant to section 164.528. Each request for an accounting will be reviewed pursuant to the rules of section 164.528. (vi) You also have a right to receive a copy of this Notice upon request.

10. **Effective Date**

The effective date of this Notice is January 1, 2014.

I acknowledge receipt of Manhattan Pain Medicine, PLLC Notice of Privacy Practices

Signature: _____ Date: _____