INTAKE WC NF PI

DATE_____ **NAME** _____

1. DOA_____ HOW DID THE ACCIDENT HAPPEN? _____

_____

_____

_____

Which body parts were injured? _____

Which is you main problem? _____

2. **TRANSPORTED** BY :

o Ambulance o Helicopter o Family o Own vehicle o Self

3. YOU WERE **FIRST TREATED** AT:

o The EMERGENCY ROOM o A DOCTORS OFFICE o SELF CARE □ICE □HEAT □OTC meds

4. **PREVIOUS SYMPTOMS**, before this accident you had:

o Similar symptoms o Same symptoms o No symptoms like this o On and off similar symptoms

5. CIRCLE IF YOU HAVE SUFFERED **OTHER ACCIDENTS**:

o Date: _____ Body parts injured _____ □Work related □MVA □Other

o Date: _____ Body parts injured _____ □Work related □MVA □Other

o Date: _____ Body parts injured _____ □Work related □MVA □Other

6. **EMPLOYMENT** AT THE TIME OF THE ACCIDENT Your occupation was? _____

BEFORE the accident YOU WERE □Working FT □Working PT □Not Working □Disabled □SSD

AFTER the accident YOU have been □Working FT □Working PT □Not Working □Disabled □SSD

7. CIRCLE IF YOUR **SYMPTOMS ARE RELIEVED BY**:

o HEAT o ICE o MOVEMENT o PAIN MEDS o REST

8. WHAT MAKES YOUR **SYMPTOMS GET WORSE**?

o ACTIVITY
o STAIRS
o BEND
o COUGH
o DRIVING
o LIFTING
o RAISE ARMS OVER HEAD
o SIT 15min 30min 1hr
o STAND 15min 30min 1hr
o WALK 5min 15min 30min 1hr
o WORK

9. Have you seen **OTHER DOCTORS FOR THIS PROBLEM**? □No

Dr's name: _____ Date _____ Treatment _____

Dr's name: _____ Date _____ Treatment _____

10. HAVE YOU HAD **TESTS DONE FOR THIS PROBLEM?** □No

MRI of: _____ Date _____ Findings _____

X-ray of: _____ Date _____ Findings _____

Other _____ Date _____ Findings _____

INTAKE WC NF PI

ECPM HEADACHE SPINE AND WELLNESS CENTER

DATE_____ **NAME** _____

11. Have you had **SURGERY FOR THIS PROBLEM?** □No
    Surgery type: _____ Date of surgery: _____
    Surgery type: _____ Date of surgery: _____

12. Have you had **PHYSICAL THERAPY FOR THIS PROBLEM?** □No □Yes; From _____ to _____

OTHER MEDICAL PROBLEMS not related to this accident:

1. High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression/Anxiety
10. Osteoporosis

□ **I HAVE NO** MEDICAL PROBLEMS

OTHER SURGERIES not related to this accident:
□NONE

1. _____ Date _____
2. _____ Date _____

LIST ALL **MEDICATIONS AND SUPPLEMENTS YOU TAKE DAILY**: □LIST ATTACHED □**I TAKE NO** MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

MEDICATION ALLERGIES: **□ I HAVE NO MEDICATION ALLERGIES**

1. _____
2. _____
3. _____
4. _____

CIRCLE IF **YOU ARE EXPERIENCING**:

- o Difficulty to hold/pass urine
- o Weight Loss without dieting
- o Pain that Wakes You Up
- o Unexplained fever

CIRCLE IF **YOU HAVE**:

1. Difficulty Walking
2. Difficulty with Stairs
3. Difficulty getting in/out the car
4. Do you Live alone? □Yes □No
5. Do you Drive? □Yes □No

IF YOU HAVE BEEN IN PAIN FOR THREE (3) MONTHS OR MORE PLEASE COMPLETE A PAIN INTAKE

I have reviewed & discussed all above information with the patient Doctor's Signature _____

INTAKE (Page 2 of 2) **DATE**_____ **NAME** _____

MEDICATION ALLERGIES ☐ I have **NO** medication allergies

1. _____
2. _____
3. _____
4. _____

YOUR MEDICAL PROBLEMS Circle if you have/had:

1. High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression/Anxiety
10. Osteoporosis

FAMILY HISTORY Circle the following if applys:

1. High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression/Anxiety
10. Osteoporosis

SOCIAL HISTORY:

Marital status: ☐Married ☐Single ☐Divorced
Do you Live alone? ☐Yes ☐No
Do you Drive? ☐Yes ☐No

PERSONAL HABITS:

Are you a current smoker? ☐Yes ☐No
Alcohol use? ☐Yes ☐No
Drug use? ☐Yes ☐No

EMPLOYMENT

Your occupation is? _____ ☐ Unemployed

1. ☐Working FT ☐Working PT ☐ Retired
2. ☐ Disabled ☐ On leave

CIRCLE IF YOU ARE **EXPERIENCING**:

- o Difficulty to hold/pass urine
- o Weight Loss without dieting
- o Pain that Wakes You Up
- o Unexplained fever

CIRCLE IF **YOU HAVE**:

1. Difficulty Walking
2. Difficulty with Stairs
3. Difficulty getting in/out the car

(I have reviewed & discussed all above information with the patient)

Doctor's Signature _____

CHRONIC PAIN
Questionnaire

FILL THIS FORM ONLY IF YOU HAVE BEEN IN PAIN FOR 3 MONTHS OR MORE

NAME: **DATE:**

Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	Tingling

Circle the number that best describes your PAIN AT IT'S **WORST DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

Circle the number that best describes your PAIN AY IT'S **LEAST DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

Circle the number that best describes your PAIN **ON AVERAGE DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

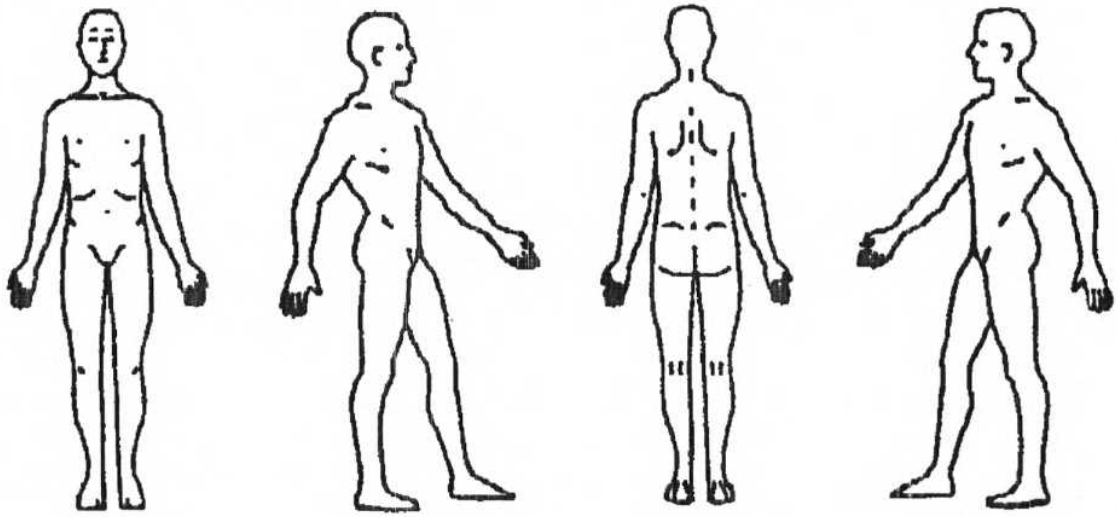
No Pain — Worse Pain

Circle the number that best describes your PAIN AS IT IS **RIGHT NOW.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

On the diagram below,
SHADE THE AREA(s) WHERE YOU FEEL PAIN. **"X" THE AREAS THAT HURT THE MOST.**



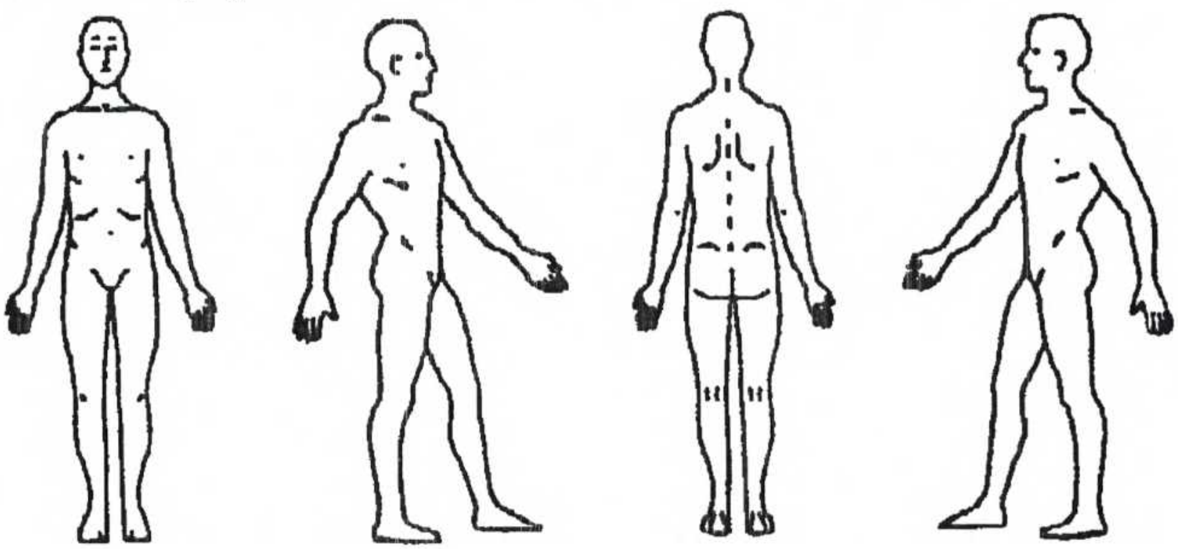
CHRONIC PAIN
Questionnaire

 NAME: **DATE:**

WHAT PAIN TREATMENTS OR MEDICATIONS ARE YOU RECEIVING NOW OR HAVE RECEIVED IN THE PAST? (For example, pain medications, physical therapy, acupuncture, TENS, etc.) Circle the number that best describes the amount of pain relief that the medication or treatment is providing or has provided.

Medication or Treatment	Not Good										Very Good	Check if taking now
______________	0	1	2	3	4	5	6	7	8	9	10	○
______________	0	1	2	3	4	5	6	7	8	9	10	○
______________	0	1	2	3	4	5	6	7	8	9	10	○
______________	0	1	2	3	4	5	6	7	8	9	10	○
______________	0	1	2	3	4	5	6	7	8	9	10	○
______________	0	1	2	3	4	5	6	7	8	9	10	○

On the diagram below, shade the area(s) where you feel **numbness and/or tingling**. Mark with an **"X"** where **numbness and/or tingling feel worse**



CHRONIC PAIN
Questionnaire

 NAME: DATE:

Circle the numbers below that best describe how pain has interfered with your daily functioning.

	"0" DOES NOT INTERFERE									TOTALLY INTERFERES "10"
Self Care Activities	0	1	2	3	4	5	6	7	8	9	10
House Chores	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Sexual activity	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10
Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Relations With Other People	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

WHAT LEVEL OF PAIN, DO YOU THINK, WOULD ALLOW YOU TO FUNCTION ON A DAILY BASIS?

No Pain **Worse Pain**

SUBSTANCE USE:

Which of the following drugs or substances, if any, have you **USED IN THE PAST?** (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you used it:
Occasionally ("O"), Frequently ("F"), or Continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin_____	Amphetamines_____	Marijuana_____
Other _____	Other _____	Other _____

Are you **PRESENTLY USING** any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it :

Occasionally ("O"), Frequently ("F"), or Continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin_____	Amphetamines_____	Marijuana_____
Other _____	Other _____	Other _____

I have reviewed & discussed all above information with the patient, Doctor's Signature _____

Date _____

Patient Name _____

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	_____	

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to 1207 Route 9 Suite 12 WF, NY 12590
(Print patient's name)
all rights privileges and remedies to payment for health care 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 any 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 the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

This 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 conduct 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 COMMERCIAL 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 A FALSE REPORT OF THE 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 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)

_____

_____ (Date of signature)

_____ (Address of Patient)

Larisa M. Bruma (Print name of Provider)

Larisa Bruma (Signature of Provider)

1207 Route 9 Ste 12
Wappingers Falls, NY 12590

Date: _____

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, **("Assignor") hereby assign to**
(Print patient's name)
all rights privileges and remedies to payment for health care 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 any 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 the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

This 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 conduct 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 COMMERCIAL 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 A FALSE REPORT OF THE 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 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)

_____
(Date of signature)

_____
(Address of Patient)

-GLADYS CARDENAS, MD-
(Print name of Provider)

1207 Route 9 Suite 12
Wappingers Falls, NY 12590

_____
(Signature of Provider)

_____
(Date of signature)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:
_____	_____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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 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 A FALSE REPORT OF THE 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 TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE 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 ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS 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 CONDUCT OF THE ASSIGNOR

Print Name _____ Signed _____
PATIENT(Assignor) PATIENT DATE

Print Name _____ Signed _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

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 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 A FALSE REPORT OF THE 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 TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE
BENEFITS ASSIGNMENT

I here by authorize and direct my (Insurance Company):_____
To pay directly to:

1207 Route 9
Wappingers Falls, Ny 12590

If in the event my current policy prohibits direct payment to the doctor, then I hereby also authorize and direct you to pay directly to:

(Your Name):_____

1207 Route 9
Wappingers Falls, Ny 12590

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance of the said professional service charges over and above this insurance payment.

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

I also authorize Dr. Gladys Cardenas of the East Coast Pain Management, P.C. to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date_____

_____
Signature of Policyholder

_____
Witness

_____
Signature of Claimant, if other than Policyholder

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant and that the has my permission to take x-rays.

Last day of menstrual period:_____ .

Signed:_____ **Date:**_____

Witness:_____ **Date:**_____

CONSENT TO TREAT / EXAMINE MINOR CHILD

I hereby give my permission to the to examine and treat my child of ward.

Child's Name:_____

Signature:_____ **Date:**_____

Witness:_____

CONSENT TO X-RAY A MINOR CHILD

I hereby give my consent to the to x-ray my child.

Child's Name:_____

Signature:_____ **Date:**_____

Witness:_____

PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM

Patient Name_____

Witness Name _____

I am taking a pain medicine called **OPIOIDS** to help improve my pain.
I agree (*patient must initial each line to show agreement):*

_____I will take my pain medicine exactly the way doctor tells me to. That means I will take the right amount of pain medicine at the right time.
_____I will tell my doctor about any new medical problems.
_____I will tell my doctor about all medicine I take, and will tell my doctor if I am given any new medicines.
_____I will tell my doctor if I see another doctor, or if I go to the Emergency Room.
_____I will only get my pain medicine prescription from this facility.
_____If my doctor is away, I will only get medicine from the doctor who is in charge while my doctor is away.
_____I will only get my pain medicine from one pharmacy (drug store).
_____I will follow my doctor's directions about therapy, exercises and physical things to do so I can learn to live with my pain.
_____I will do what I can to get back to work.
_____I will not drink alcohol or use any other drugs unless I am told to do it by my doctor.
_____When I am asked, I will get lab tests to see if I am taking my medicines the right way.
_____If the lab tests show that I am not taking the medicines the way I should, my doctor may cut down or stop my medicine or send me to a specialist or special program to help care for me.
_____I will store my pain medicine in a safe place where other people cannot take it.
_____I will keep my scheduled appointments. If I must miss an appointment, I will call my doctor to cancel at least 24 hours before the appointment.
_____I am not pregnant and I will call my doctor as soon as possible if I think I may be pregnant.

My doctor may stop giving me pain medicine if:

- I do not follow this agreement.
- The pain medicine is not helping me.
- I'm not meeting my goals in active therapy.
- My pain or my functions do not improve.
- I have bad side effects from the pain medicine.
- I become addicted to the pain medicine.
- I give or sell the pain medicine to someone else.

Patient Signature: _____ Date:_____
I attest that this form was reviewed by me with the patient and all questions were answered.
Doctor Signature:_____ Date:_____

PATIENT INFORMED CONSENT FOR TREATMENT WITH OPIOIDS FORM

Patient Name_____

Witness Name_____

I plan to take a pain medicine called **OPIOIDS.** This pain medicine may help improve my pain but it may also cause some serious problems. The problems may be worse if I mix the pain medicine with alcohol or other drugs.

I understand that the pain medicine I will be taking may cause serious problems including:

⇨ Confusion.
⇨ Poor judgment.
⇨ Nausea (a stomach ache).
⇨ Vomiting.
⇨ Constipation (hard stools that may be painful to push out).
⇨ Sleepy or drowsy feeling.
⇨ Poor coordination and balance (such as feeling unsteady, tripping, and falling).
⇨ Slow reaction time.
⇨ Slow breathing or I can stop breathing - which could cause me to die.
⇨ More depression (such as feeling sad, hopeless, or unable to do anything).
⇨ Dry mouth.
⇨Increased feeling of pain (hyperalgesia).
⇨Addiction (it may be very hard to stop taking the pain medicine when I'm ready to quit).
⇨For men: the pain medicine may lead to less interest in sex and poor sexual performance.
⇨For pregnant women, the pain medicine may hurt my unborn child and may cause my child to be born addicted to the pain medicine.

I will tell my doctor if I have any of the problems listed here.
I understand there may be other problems caused by the pain medicine, in addition to the problems listed here.
I understand that these problems may get better when I stop taking the pain medicine.
My doctor has reviewed the serious problems that this pain medicine may cause. My doctor has answered all questions that I have about this pain medicine and the serious problems it may cause.

Patient Signature:_____ Date:_____
I attest that this form was reviewed by me with the patient and all questions were answered.
Doctor Signature:_____Date:_____

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

EFFECTIVE DATE: 9/19/2013

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

EFFECTIVE DATE: 9/19/2013

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

PLEASE BE ADVISED THAT OPEN TREATMENT AREAS ARE USED IN THIS OFFICE FOR PART OF YOUR CARE. PRIVATE TREATMENT AREAS ARE AVAILABLE UPON REQUEST.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

I acknowlegde receipt of a copy ofP.C.'S**Notive of Privacy Practices.**

Signature of Patient:_____

Date:_____

EFFECTIVE DATE: 9/19/2013