NEW PATIENT HEALTH INTAKE FORM

Name (Last, First, Middle): _____ Height: _____
Date of Birth:____/____/____ Age:_____ Sex: ____Male ____Female Other_____
Marital Status ___Single ___Married ___Widow ___Divorce ___Other
Address:_____ City:_____State:_____ Zip:_____
Home Phone:_____ Cell/Work Phone:_____
Occupation:_____
Employer/School Name & Address:_____
Emergency Contact Person:_____ Phone:_____
Allergies: __NO __YES please list:_____

INSURANCE INFORMATION

Primary Insurance
Insurance name: _____
Subscriber: _____
Policy Number: _____
Group Number: _____
Insured's DOB: _____
No Fault: _____
Claim Number: _____

Secondary Insurance
Insurance Name: _____
Subscriber: _____
Policy Number: _____
Group Number: _____
Insured's DOB: _____
Workers Compensation: _____
Policy Number: _____

PHYSICIAN(S) INFORMATION

Referring Physician: _____ Phone #:( )_____
Primary Care Physician: _____ Phone #:( )_____

TRIGGER POINT INJECTION CONSENT

THE TREATMENT

Trigger point injections (TPI) is used to treat extremely painful and tender areas of muscle. Normal muscle contracts and relaxes when it is active. A trigger point is a knot or tight band in muscle that forms when muscle fails to relax. The knot often can be felt under the skin and may twitch involuntary when touched (called a jump sign). The trigger point can trap or irritate surrounding nerves and cause referred pain-pain felt in another part of the body or in teeth. Scar tissue and loss or range of motion and weakness may form over time. A small needle is inserted into the trigger point and local anesthetic (e.g., Lidocaine), and or Sarapin is Injected and have been found to be very effective in relieving pain, and may be used in combination with home exercise, heat, cold and individualized

RISK AND COMPLICATIONS

Before undergoing the procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks that are not Included on this list. Some of these risks, if they occur, may necessitate additional surgery, prolonged hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential to; 1. You may develop infection; 2. You may experience bleeding; 3. You may develop irritation at the injection site; 4. There may be skin changes; 5. You may develop bruising, redness or swelling; 6. The lung (or the pleura, which Is the surrounding membrane) may be punctured if the procedure is performed In a muscle near the ribcage, and 7. The procedure may fail to reduce the pain symptoms.

RESULTS

You may receive the following benefits. The doctors cannot guarantee you will receive any of these benefits. Only you can decide if the benefits are worth the risk. Trigger point injections are used to alleviate myofascial pain syndrome (chronic pain involving tissue that surrounds muscle) that does not respond to other treatments, although there is some debate over its effectiveness. Many muscle groups especially those in the arms, legs, lower back, and neck are dysfunction, and other types of orofacial pain.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with trigger point injections for myofascial pain. TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____ _____ _____
Patient's Name (or guarantor) Signature Date

_____ _____ _____
(Provider) Name Signature Date

PATIENT MEDICAL INFORMATION

CHIEF COMPLAINT (S)/ INJURY DESCRIPTION

Patient Name: _____ DOB: _____

•Chief Complaint(s):_____

•Onset date: when did this symptom (s) begin?_____ • Have you had this symptom(s) before? __ No __Yes when?_____

•**IS this an injury**? __NO __Yes: Date of Accident/Injury:___/___/___Location:_____

Nature of the injury: __**Auto Collision** __**On-the-Job Injury** __Other Description:_____

If auto accident, you were a __Driver __Passenger __Pedestrian and struck from __Behind __Rt. Side __Lt Side __Front

If an Attorney is Involved, Attorney's Name:_____ Phone:_____

•Are you currently working? __N/A __No __Yes: if no, last date worked:_____ If yes, any restrictions?_____

• Have you had Surgery for this Injury? __No __Yes: Type of surgery:_____ Date of surgery:_____

•Medical Care/Treatment related to current condition/injury (check all that apply and write date of the care/treatment)

□Primary Doctor:_____ □X-Ray:_____ □Orthopedic Dr.:_____

□ Neurologist:_____ □MRI:_____ □Chiropractor:_____

□Physical Therapy:_____ □Other:_____

•Have you received any Physical Therapy Service this year? □None □1-5 visits □6-10visits □11-15 visits □16-20 visits □ ≥ 21 visits

PAIN HISTORY DESCRIPTION

• How would you rate your pain on a scale of 0-10?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate		Severe		Very Severe		Worst

• Pain Description (mark all that apply)

□ Sharp □Stabbing □Dull □Aching □Burning □Numb/Tingling □Spasm/Stiff □Radiating

• What makes It better? Activity:_____ Time of day:_____

• What makes It worse? Activity:_____ Time of day:_____

• Check those activities below during which you experience difficulty:

□ Sit to Stand □ Standing for long time □Walking □ Stair Climbing □ Running □Sports

□ Pulling □ Pushing □ Lifting □ Bending forward/backward □ Squatting □ Sitting for long time

□ Dressing □Toileting □ Bathing □ Getting In/out of car □ Sexual Activity □ Grocery Shopping

MEDICAL CONDITION/MEDICATIONS

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

□ AIDS/HIV positive	□ Epilepsy	□ Osteoporosis	□ Endometriosis
□ Gout	□ Pacemaker	□ Miscarriage	
□ Anemia	□ Heart Attack	□ Parkinsonism	□ Heart Surgery_____
□ Arthritis	□ Hepatitis	□ Pneumonia	□ Vaginal Infection
□ Asthma/Bronchitis	□ Hernia	□ Prostate Problem	□ Pins/Metal Implants:_____
□ Blood Clot	□ High Blood Pressure	□ Sleeping Problems	□ Joint Replacement:_____
□ Cancer: _____	□ High Cholesterol	□ Stroke/TIA	□ Neck/Back Surgery
□ Cataracts/Glaucoma	□ kidney disease:_____	□ Thyroid Problems	□ Shoulder/Arm/Hand Surgery
□ Coronary Heart Disease/Angina	□ Liver Disease:_____	□ Ulcers:_____	□ Knee/Ankle/Foot Surgery
□ Pelvic Inflammatory Disease	□ Incontinence(urinary/Fecal)	□ Multiple Sclerosis	□ Migraine/Headaches
□ Complicated Pregnancy/Delivery	□ Diabetes	□ Emphysema/COPD	□ Other:_____

List Medications/Drugs/Supplements/Herbs you are currently taking:_____

Allergies: NO □ YES □ List all: _____

Rutman Medical PLLC
148 Natures Lane
Miller Place NY 11764
Phone: 631 886 1500

OUT OF NETWORK DISCLOSURE FORM AND FINANCIAL AGREEMENT

Thank you for choosing our facility for your care. We are committed to providing quality medical care for you. To reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it prior to beginning treatment.

Out of Network:

We are an out of network health care provider with most health care plans. In many instances, your health care plan may not fully pay our charges for medical services. As a result we have the obligation to bill you for coinsurances, deductible and costs share amount for non-covered services. You the patient agree that you will be responsible for these potential fees.

Should your insurer remit payment to you directly for services provided, you agree to immediately forward those payments to Rutman Medical PLLC. Insurance checks must be endorsed on the back to Rutman Medical PLLC after which the patient will sign their name.

Overdue Balances:

Should payment for services not be forthcoming, the matter may be referred to an attorney for collection. If the matter is sent to an attorney, in addition to the full balance due, the patient will also be responsible for legal fees and court costs in connectioin with the collection.

I hereby authorize Rutman Medical PLLC/North Fork Medical PLLC to release information required by my insurance company for payment of my medical bills or to review activities related to my healthcare provider's participation in my health plan. I assign Rutman Medical PLLC/North Fork Medical PLLC any and all benefits to which the patient or insured party is entitled for medical services rendered.

I have read this Financial Policy and agree to abide by it:

Patient Name (Please Print)	Signature of Patient or Guardian	Date

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	Date of Birth	Social Security Number
Patient Address		

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:

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 _____ (Initials) I authorize _____ (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: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
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.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.