Orlin & Cohen Medical Specialists Group

Patient Label

NYS NO FAULT PATIENT REGISTRATION

Today's Date _____ Date of Accident _____Which physician are you seeing today?_____

Last Name _____ First Name _____

Address _____ Home Phone _____

City, State, Zip _____ Work Phone _____

Email Address _____ Cell Phone _____

SS# _____ Date of Birth _____ Age _____ Sex ( ) Male ( ) Female

Preferred Method of Communication: Please choose from the following: Email ( ) Phone-home ( ) Phone-cell ( ) Phone-work ( ) Mail ( ) Other _____

☐ By checking this box, I certify that I am 18years of age or older, the email address provided is my personal email address, and I also consent to receiving on going communication from Orlin & Cohen Medical Specialists Group including company news, information and announcements.

Provider may send me email messages such as appointment reminders, statements, or other material. ( ) Yes ( ) No

Were you referred here for a consultation by another Physician, Physical Therapist or Lawyer? ( ) Yes ( ) No
If yes, who is requesting this?

_____/_____/_____
Name Address Phone/Fax

Are you currently working? ( ) Yes ( ) No Retired? ( ) Yes ( ) No Last date worked? _____

Employer _____ Office Phone _____ Occupation _____

Address _____ City _____ State ____ Zip _____

Who is your Primary Care Physician? _____Phone _____

Physician's Address _____

AUTO INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____

Policy No. _____ Claim No. _____

Policy Holder _____ Phone _____

Attorney Name _____ Phone _____

Address _____

Have you submitted your *Application for Benefits* to your insurance company? ( ) Yes ( ) No

Name of Examiner _____ Phone _____

PLEASE LIST THE PATIENTS PRIVATE INSURANCE INFORMATION BELOW

Name of Insured _____ Date of Birth _____ SS# _____

Address _____ City _____ State ____ Zip _____

Employer _____ Office Phone _____

_____/_____/_____

Last Name **First Name** **Appointment Date** **What Dr. are you seeing today?**

CC: Chief complaint: What is the reason for this visit?_____

Did you bring films/disc? X-Ray ☐ Y ☐ N **MRI** ☐ Y ☐ N **CD/DVD** ☐ Y ☐ N

Location: What is the location of your injury? ***Check all that apply***

☐ Spine/Back ☐ Neck ☐ R Shoulder ☐ L Shoulder ☐R Arm ☐ L Arm ☐ R Elbow ☐ L Elbow ☐ L Wrist ☐ R Wrist
☐ R Hand ☐ L Hand ☐ R Hip ☐ L Hip ☐ Toes ☐ Finger ☐ Pelvis ☐Chest ☐ Ribs ☐Clavicle
☐R Leg ☐ L Leg ☐ R Knee ☐ L Knee ☐ R Ankle ☐L Ankle ☐ R Foot ☐ L Foot Other:_____

Please write specific details of your problem (if accident/injury, list details):

_____

_____

Are you being treated by another physician for this condition/injury? ☐ Y ☐ N If yes: Dr. _____

What tests/scans have you had for this problem? ☐ X-Ray ☐MRI ☐ CT Scan ☐Bone Scan ☐

If yes, where? _____

Dominant Hand ☐ L ☐ R ☐ Ambidextrous (both)

Nerve Test (EMG/NCV)

If this injury was due to a MOTOR VEHICLE ACCIDENT, please answer the questions below

Were you wearing a seat belt at the time of the accident? ☐ Y ☐ N **Did your airbag deploy?** ☐ Y ☐ N

Your Car: ☐ Hit another car Was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front **Type of Accident:**
☐ Head on collision ☐ Broad side collision ☐ Rear end collision
☐ Front impact ☐T collision ☐ You were a Pedestrian

Date of Accident: _____

Did you go to the hospital for this problem? ☐ Y ☐ N **If yes, which hospital?** _____

Size of Vehicle _____ **Type of Vehicle** _____

Did you hit another vehicle?: ☐ Y ☐ N **Did you hit a fixed object?:** ☐ Y ☐ N

If yes, what was the fixed object? _____

Were you the: Driver / Passenger / Pedestrian **Were you in traffic?:** ☐ Y ☐ N

What type of pain do you have? ☐Burning ☐Diffuse ☐Dull/Aching ☐Localized ☐Radiating ☐ Sharp
☐Shooting ☐Stabbing ☐Throbbing ☐Tightness ☐Tingling

What is your level of pain when active ? *Please Circle* 0 1 2 3 4 5 6 7 8 9 10 most severe

What is your level of pain at rest? *Please Circle* 0 1 2 3 4 5 6 7 8 9 10 most severe

What is your severity of pain? *Please Circle* 0 1 2 3 4 5 6 7 8 9 10 most severe

Duration: How long have you had your pain? 1 2 3 4 5 6 7 8 9 10 11 12 Hours / Days / Weeks / Months / Years

_____/_____

Last Name **First Name** **Date**

Have you had a problem like this before? ☐Y ☐ N **Date original problem/condition started?** _____

Is your pain with activity? ☐ Constant or ☐ Intermittent (comes and goes) ☐ Frequent ☐ Occasional

Does your pain affect your ability to asleep? ☐ Y ☐ N

When do you have the worst pain? ☐Morning ☐ Afternoon ☐Night ☐with Activity

Does your pain get better with? *Please Circle* Warmth or Cold **Does it get worse with?** Warmth / Cold / Dampness

What makes your symptoms/pain worse? ☐Stretching ☐Sitting ☐Standing ☐Twisting ☐Walking ☐ Bending ☐ Squatting ☐Kneeling ☐Warmth ☐Cold ☐Lifting ☐ Exercise ☐Stairs ☐ Lying in bed ☐ Coughing ☐ Other: _____

Context: Which make your symptoms/pain better? ☐Rest ☐Rx Meds ☐ Elevation ☐ Ice ☐ Heat ☐Massage
What are you treating your pain with? _____

Have you had any of these treatments? ☐ Injections ☐ Brace/s ☐ Physical Therapy

Associated signs and symptoms: Do you have any of the following? ***check all that apply*** ☐ None (denies any symptoms)
☐Blurred Vision ☐Depression ☐Irritability/Mood Swings ☐Localized Tingling ☐Nausea ☐Ringing in Ears ☐Stiffness ☐Headaches ☐Weakness ☐Aches ☐Burning ☐Cold Limb(s) ☐Difficulty Walking ☐Sleep Disturbance ☐Dizziness ☐Ecchymosis ☐Chronic Fatigue ☐Fever ☐Heartburn ☐Joint Stiffness ☐Muscle Spasm ☐Muscle Weakness ☐Numbness ☐Pale Bluish Skin ☐Pins & Needles ☐Rhinorrhea ☐Shortness of Breath ☐Sweating ☐Swelling ☐ Locking/Catching ☐Loss of control of bladder or bowel ☐ Bruises

REVIEW OF SYSTEMS **Have you had any problems related to the following systems?** ***Circle all that apply***

Constitutional Systems	Chills	Fever	Headache	None
Eyes	Blurred	Double Vision	Vision Change	None
Ear/Nose/Throat	Earache	Sore Throat	Sinus Congestion	None
Cardiovascular	Chest Pain	Shortness of Breath	Palpitations	None
Respiratory	Chronic Cough	Wheezes	Asthma	None
Gastrointestinal	Abdominal Pain	Nausea	Bowel Habit Changes	None
Genitourinary	Frequent Urination	Urine Retention	Kidney Problems	None
Musculoskeletal	Neck Pain	Back Pain	Joint Pain	None
Skin	Rash	Skin Discolor	Persistent Itch	None
Neurologic	Stroke	Weakness	Vertigo	None
Psychiatric	Anxiety	Depression	Sleep Disorders	None
Endocrine	Thirst Increase	Sweats	Thyroid Disease	None
Hematologic/Lymphatic	Swollen Glands	Blood Clotting Problem	Anemia	None
Allergic/Immunologic	Hay Fever			None

Pharmacy Information Sheet

We can send your prescriptions directly to your pharmacy so that there is less waiting time for you. If you know your pharmacy, please complete the below form. Please be aware that the easiest way for us to find your pharmacy is to know the zip code.

Your Name:		Date of Birth:
Pharmacy Name:		
Address:		
City:	State:	Zip:
Pharmacy Phone #:	Pharmacy Fax:	

_____/_____

Last Name **First Name** **Date**

Vitals: **What is your height and weight? Height:** _____ Ft _____ Inches **Weight:** _____ lbs _____ oz

Do you take anti coagulants? (blood thinners) ☐ Plavix/Clopidogrel ☐ Coumadin/Warfarin ☐ Fragmin ☐Lovenox ☐ Platal
check all that apply

PAST MEDICAL HISTORY (PHX)

Have you had any prior Orthopedic Surgery? □ Yes □ No If yes: Procedure & Date_____

Please list any other Surgery you have had by operation (type) and date: _____

CURRENT PERSONAL ILLNESSES: ***Check all that apply***
□ None (denies any personal illnesses)
□ Diabetes □ Heart Disease □ High Blood Pressure □ Elevated Cholesterol □ Lung Disease □ Thyroid Disease □ Ulcers
□ Peripheral Vascular Disease □ Cancer □ Pacemaker □ Kidney Disease □ Liver Disease □ Seizures □ Psychiatric Disorders
□ Serious Infection □ HIV □ Hepatitis □ Other _____, _____

FAMILY HISTORY (FHX)

Is there a family history of medical or orthopedic conditions? □ Yes □ No
If yes; please list _____, _____, _____

Which family member: (Mother, Father, Sister) _____,_____,_____

Have you or any family member had a blood clot (Deep Vein Thrombosis)? □ Yes □ No

SOCIAL HISTORY (SHX) ***Check all that apply***

Marital Status: □ Single □ Married □ Divorced/Separated □ Widowed □
Smoking Status: □ Never Smoked □ Former Smoker □ Current every day Smoker □ Current someday Smoker
If you smoke, how many packs a day? _____

Alcohol usage: □ Non-Drinker □ Social Drinker □ Alcoholic **Have you been treated for alcohol addiction?** □ Yes □ No

Drug usage: □ Yes □ No If yes; (check off type used) □ Marijuana □ Cocaine □ Amphetamines □ Other_____

Have you been treated for drug addiction? □ Yes □ No

Do you now or have you ever used illicit or intravenous drugs? □ Yes □ No

MEDICATIONS: please list current medications and doses _____/_____

_____/_____/_____

ALLERGIES: Do you have any allergies? □ Yes □ No
Drug Allergy □ Yes □ No If yes; Drug Name _____Type of Reaction & Date _____

Food Allergy □ Yes □ No If yes; Food _____ Type of Reaction & Date _____

Environmental Allergy (example; latex, dust, pet dander, grass) □ Yes □ No

If yes, what are you allergic to?_____Type of Reaction & Date_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> for verification of hospital treatment)

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

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE <u>BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT</u>. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM**.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: _____	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:
FROM: _____ THROUGH: _____	_____ (DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
YES ☐ NO ☐ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____
PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

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 INJURIES 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.

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** _____ **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider 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)

Orlin & Cohen Medical Specialists Group
_____ _____
(Print name of Provider) **(Signature of Provider)**

PO Box 412013 _____
(Date of signature)

Boston, MA 02241-2013
_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

Date _____ Patient Name_____

CONSENT INFORMATION

CONSENT TO TREAT

This information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of Orlin & Cohen Medical Specialists Group to administer such procedures and treatment as they deem necessary. They have implied no guarantee of cure.

Patients Initials_____ Date_____

CONSENT TO TREAT A MINOR CHILD

The information I have given this office pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors and staff of Orlin & Cohen Medical Specialists Group to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The doctors have implied no guarantee of cure.

Parent/Guardian Initials_____ Date_____

FOR WOMEN ONLY

The doctor or a staff member of Orlin & Cohen Medical Specialists Group has advised me that x-rays can be hazardous to an unborn child. At this time and the best of my knowledge, I am not pregnant. I consent to having x-rays taken.

Patients Initials_____ Date_____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

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

I also authorize the release of information pertinent to my case to my insurance company, claims adjuster or attorney involved in this case. Patients Initials_____ Date_____

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

Orlin & Cohen Medical Specialists Group
PO Box 412013
Boston, MA 02241-2013

Patient/Guardian Signature _____ Date_____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy of Orlin & Cohen Medical Specialists Group's HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information _____

Signature_____ Date_____

HIPAA AUTHORIZATION TO RELEASE

I authorize/give permission to the following people to receive my protected health information. List school, office etc…
_____Signature_____ Expiration Date: _____

CONSENT TO ACCESS THE NATIONAL RXHUB

I have agreed to allow Orlin & Cohen Medical Specialists Group to access my current list of medications via the National RxHub.

Signature_____ Date_____