David S. Feldman, MD, PC

Feldman Center for Scoliosis and Spinal Deformity | Hip Preservation | Limb Reconstruction Surgery
Toll Free: 844-714-5293

Last_____First_____M_____

Home Address_____

City_____State_____Zip code_____

Local Address (if different from above)_____

City_____State_____Zip code_____

Daytime / Work No. ( )_____ Home ( )_____

Cell No. ( )_____
Local No. ( )
_____

Date of Birth _____

Age _____ Sex:
Female / Male

Marital Status (Circle One): Single Married Divorced Widowed

How would you like to be addressed?_____

Email Address _____

If patient is a minor, Father's Name _____ Mother's Name _____

Patient's Employer_____ Occupation _____

Address _____ City _____ State _____ Zip Code _____

Emergency Contact Person _____

Relationship _____ Home No. ( ) _____ Work No. ( )_____

Is your visit due to: Auto Accident _____ If yes, date of accident _____

Worker's Comp. _____ If yes, date of accident _____

Whom may we thank for referring you to our office? _____

If referred by a physician: Name _____ Office No. ( ) _____Fax No. ( )_____

Address _____ City _____ State _____ Zip Code _____

INSURANCE

Are you personally responsible for the payment of your fees? Yes No If no, who is?

Name _____ Relationship _____ DOB _____

Address _____ City _____ St _____ Zip Code _____

Name of Primary Insurance Company _____

Policy #_____Group #_____

Insured's Name _____ Relationship _____

Date of Birth _____

Name of Secondary Insurance Company _____

Policy # _____ Group # _____

Insured's Name _____ Relationship _____

Date of Birth _____

PLEASE READ AND SIGN THE FOLLOWING:

1. Payment for services is expected at time of service.
2. If insurance is filed, I authorize benefits to be paid directly to David S. Feldman, MD, PC.
3. I am responsible for the balance on my account, regardless of insurance coverage. My failure to pay all outstanding balances on my account may result in collection procedure.
4. I authorize the David S. Feldman, MD, PC, to release any information requested with regard to the processing of my claims.
5. Failure to give 24 hour notice prior to canceling appointments may result in a cancellation fee charge to my account not payable by health insurance.

Patient's /Parent 's

Signature _____ Date _____

Preferred Pharmacy's Name_____
Address _____

City_____State_____Phone No._____

Second Pharmacy's Name_____ Address _____

City_____State_____Phone No._____

Census Data:

Religion _____ Ethnicity _____

Circle One: Hispanic Non-Hispanic

Please choose from the following list for your **Race**:

Alaskan Native	Indian	Unknown
Asian	Multi-racial	Not Reported
Black/African American	Native American	White
Hawaiian	Other Race	
Hispanic	Pacific Islander	

Please choose from the following list for your **Preferred Language**:

Albanian	Dutch	Hungarian	Other	Sudanese
Arabic	English	Indonesian	Pakistan	Swahili
Armenian	Estonian	Italian	Polish	Swedish
Azerbaijani	Farsi	Japanese	Portuguese	Tagalog
Bosnian	Filipino	Korean	Romanian	Taiwanese
Bulgarian	Finnish	Laotian	Russian	Thai
Cambodian	French	Lebanese	Samoan	Turkish
Chinese	German	Lithuanian	Serbo-Croatian	Ukrainian
Creole	Greek	Malayan	Sign Language	Vietnamese
Czech	Hebrew	Mandarin	Slovak	Yiddish
Danish	Hmong	Norwegian	Spanish	

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Financial Policy

We appreciate the confidence that you have expressed in selecting David Feldman, MD, PC, for your healthcare needs and we look forward to working with you. If you have any questions about our services, fees, or other aspects of your care, please feel free to discuss your concerns with us.

A payment for your office visit is required at the time of service for:

- Patients without insurance.
- Patients with private insurance.
- Patients who are not covered by one of our contracted insurance plans.
- Patients who do not provide us with contracted insurance information. (We must have a copy ofyour current insurance card on file.)

ALL MONIES OWED BY THE PATIENT: CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES ARE PAYABLE AT THE TIME OF SERVICE.

For any service that is rendered by this office that is not a covered benefit of your insurance policy, it is your financial responsibility.

Our staff will assist you in dealing with your insurance company, but it is your responsibility to know and understand your own insurance policy. It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstanding at a later date.

Patient Name: _____

Patient's / Parent's Signature: _____ Date:_____

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Authorization to Release Medical Records

PATIENT:

_____ Name of Patient/Previous Names

_____ Birth Date

_____ Street Address

_____ City, State, Zip

AUTHORIZES MY CURRENT PHYSICIAN:
David S. Feldman, MD
Physician Name

_____
Street Address

New York, NY 10003
City, State, Zip

TO RELEASE PROTECTED HEALTH INFORMATION TO:

_____ Physician Name/Self

_____ Street Address

_____ City, State, Zip

INFORMATION TO BE RELEASED:

I hereby authorize you to release **all** of my medical records for any treatment and laboratory/diagnostic tests performed **except for information pertaining to:**

____Sexually transmitted disease
____Treatment of alcohol or substance abuse
____Records from other facilities/providers
____Testing or treatment of HIV/AIDS
____Communication between patient and psychotherapist for mental health treatment

For the following date(s):_____

PURPOSES FOR NEED OF DISCLOSURE: (check one)
____Further Medical Care
____Insurance/Eligibility
____Other (specify):_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted health care provider. I understand David S. Feldman, MD, PC will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, David S. Feldman, MD, PC, will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE**: _____
(If signed by other than patient, state relationship and authority to do so)

EXPIRATION DATE: This authorization is good until the following date(s):_____ or for six months from the date signed.

Distribution of Copies: Original to provider; copy to patient; copy to accompany released records.

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Authorization for Use and Disclosure of Individually Identifiable Health information and Confidential Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize to a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information: David S. Feldman, MD, PC, and its employees or contractors.

2. I acknowledge and agree that the practice may disclose my protected health information and information contained in my medical record to the following (check allowances) Spouse Adult children All family members Legal representatives Guardians Health care surrogates Other _____ All listed

3. Specific information that may be used/disclosed: information relating to treatment, payment, and health care operations.

4. The information will be used/disclosed for: treatment, payment, and health care operations.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

6. I understand that Imay inspect or copy the information used or disclosed.

7. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that (a) action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

8. I have read and agree to the information regarding "How We May Use and Disclose Medical Information about You." Our notice of "Privacy Practices" (posted in reception) provides information about how we may use and disclose health information about you. You have the right to review our notice before signing this form. The practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If so, the patient may obtain a copy of this revised Notice. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

9. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

10. Patient agrees and consents to the practice releasing information to the patient in the following alternative manners:
    Via regular mail with envelope being marked personal and confidential, and addressed to the patient.
    Via telephone, if the patient contacts the practice and provides the appropriate information (name, SSN, birth date).

The practice may refuse to treat the patient if he/she (or an authorized representative) does not sign this consent form. If the patient (or an authorized representative) signs this consent form, and then revokes it, the practice has the right to refuse to provide further treatment to the patient as of the time of revocation (except as the practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient, or am authorized to act on behalf of the patient to sign this document verifying consent of the above stated terms.

_____ _____

Signature of patient or patient's representative **Date**

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A notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1. How medical information about you may be used or disclosed; 2. Your rights to access your medical information, amend yourmedical information, request an accounting of disclosures of your medical information, and request additional restrictionson our uses and disclosures of that information; 3. Your rights to complain if you believe your privacy rights have been violated; and 4. Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient or the patient's personal representative.

_____ _____

Name of Patient Signature ofPatient

_____

Date Signed

_____ _____

Name of Patient's Personal Representative Signature of Patient's Personal Representative

_____

Date Signed

FOR INTERNAL USE ONLY

_____ _____

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

Patient was unable to sign.
Patient refused to sign.
Other: _____

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CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT FORM · 02/99

CONSENT FOR MEDICAL SERVICES & TREATMENT

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by David S. Feldman, MD, PC.

FINANCIAL AGREEMENT

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency fees and expenses. The undersigned understand that David S. Feldman, MD, PC, has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

ASSIGNMENT OF BENEFITS

In the event that I am entitled to physician benefits of any and all types, I assign such benefits to David S. Feldman, MD, PC, for services rendered to me. I authorize payment directly to David S. Feldman, MD, PC, of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/liability insurance, or any governmental program such as Medicare, Medicaid, or Worker's Compensation and authorize David S. Feldman, MD, PC, to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

RELEASE OF INFORMATION

I also authorize David S. Feldman, MD, PC, to release all or part of my medical record information when required or permitted by law or government regulation, including any physician(s) or healthcare provider responsible for continuing my care.

INSURANCE PRECERTIFICA TION

I understand that, before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance.

LIFETIME MEDICARE B & MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in the David S. Feldman, MD, PC, including physician services. I authorize any holder of medical or other information about me to release to the Centers of Medicare & Medicaid Services or its agents any information needed to determine these benefits or benefits for related services.

_____
Name of Beneficiary

HIC Number

LIFETIME MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf for any services furnished to me by or in the David S. Feldman, MD, PC, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services.

_____
Name of Medigap Insurer

_____
Name of Beneficiary

_____
Medigap Policy Number

CONSENT FOR MEDICAL SERVICES & TREATMENT

I have been provided with a copy of the SMHCS Notice of Privacy Practices that describes how David S. Feldman, MD, PC, may use and disclose my health information, and also describe my rights regarding my health information.

EVALUATION OR SERVICES AND FOLLOW-UP

I give permission for David S. Feldman, MD, PC, and/or its agent(s) to contact me for the purpose of evaluation the services rendered to me.
YES NO

The undersigned certifies that he/she has read and understands the above, fully accepts all specified terms therein, and has received the information on patient rights, including the mechanism for initiation, review, and resolution of complaints and a copy of the SMHCS Notice of Privacy Practices.

_____
Signature of Patient of Legally Authorized Representative

_____ / ____ /
Print Name of Patient or Legally Authorized Representative — Date

_____
Signature of Guarantor of Payment
(state relationship if other than patient)

_____ / ____ /
Print Name of Guarantor of Payment — Date

_____
Signature of Witness

_____ / ____ /
Print Name of Witness — Date

MEDICAL HISTORY
REVIEW OF SYSTEM FORM

Name:_____ Date: _____
Age: _____ Height: _____ Weight: _____

PAST ILLNESSES OF YOURSELF AND FAMILY:

YOU	FAMILY		YOU	FAMILY		YOU	FAMILY	
		ALCOHOLISM			HIGH BLOOD PRESSURE			STROKE
		ANEMIA			KIDNEY DISEASE			SUICIDE ATTEMPT
		ASTHMA			LIVER DISEASE			THYROID DISEASE
		CANCER/TUMOR			HEPATITIS			TUBERCULOSIS
		DIABETES			LUNG DISEASE			ULCERS
		DIVERTICULITIS			MIGRAINES			VENEREAL DISEASE
		DEPRESSION			OSTEOARTHRITIS			HIGH CHOLESTEROL
		EPILEPSY/SEIZURES			OSTEOPOROSIS			HIV/IMMUNE DX
		GLAUCOMA			PHLEBITIS			OTHER _____
		HEART DISEASE			RHEUMATICC ARTHRITIS			

PAST SURGICAL IIISTORY: (PLEASE INCLUDE DATES)

_____

_____

_____

_____

REVIEWS OF SYSTEMS - PLEASE CHECK EACH ITEM "YES" AS THEY RELATE TO YOUR HEALTH:

	YES		YES		YES
CONSTITUTIONAL:		**RESPIRATORY:**		**HEMATOLOGY/LYMPH:**	
Weight Loss		Cough Easy		Bruising	
Fatigue		Coughing Blood		Gums Bleed Easily	
Fever		Wheezing		Enlarged Glands	
EYES:		Chills		**MUSCULOSKELETAL:**	
Glasses/Contacts		**GASTROINTESTINAL:**		Joint Pain/Swelling	
Eye Pain		Heartburn/Reflux		Stiffness	
Double Vision		Nausea/Vomiting		Muscle Pain	
Cataracts		Constipation		Back Pain	
EAR,NOSE,THROAT:		Change in BMs		**SKIN:**	
Difficulty Hearing		Diarrhea	D	Rash/Sores	
Ringing in Ears		Jaundice		Lesions	
Vertigo		Abdominal Pain		Itching/Burning	
Sinus Trouble		Black or Bloody BM		**NEUROLOGICAL:**	
Nasal Stuffiness		**GENITOURINARY:**		Loss of Strength	
Frequent Sore Throat		Burning/Frequency		Numbness	
CARDIOVASCULAR:		Nighttime		Headaches	
Murmur		Blood in Urine		Tremors	
Chest Pain		Erectile Dysfunction		Memory Loss	
Palpitations		Abnormal Discharge		**FEMALES ONLY:**	
Dizziness		Bladder Leakage		Age Onset Periods _____	
Fainting Spells		**ALLERGIC/IMMUNOLOGIC:**		Periods Regular? Yes____ No____	
Shortness of Breath		Hives/Eczema		Number of Pregnancies _____	
Difficulty Lying Flat		Hay Fever		How Many Children? _____	
Swelling Ankles		**PSYCHIATRIC:**			
ENDOCRINE:		Anxiety/Depression			
Loss of Hair		Mood Swings			
Heat/Cold Intolerance		Difficulty Sleeping			

SIGNATURE / REVIEWING PHYSICIAN _____

FAMILY HISTORY:

	Living or Deceased	Age	Cause of Death	Medical Problems
Mother				
Father				
Sibling				

Medication Taken Regularly (Please include vitamins, hormones, birth control, aspirin, sleeping tabs, etc.):

NAME	**DOSE**	**FREQUENCY/TIMES**

Medication Allergy: _____YES _____NO

Name of Medication(s):

_____

_____

BLOOD TRANSFUSIONS

Have you ever had a blood transfusion?_____YES_____NO

If yes, what year?

SOCIAL:

Smoke: _____YES _____ NO Frequency _____

Drink: _____ YES _____ NO Frequency _____

Drugs: _____ YES _____ NO Frequency _____

Exercise: _____ YES _____ NO Frequency _____

Please list below any medical issues we should be aware of:

_____

_____

_____

_____

_____