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,

11.	YES	NO
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

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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)? YES ☐ NO ☐	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
17. DID YOU LOSE TIME FROM WORK? YES ☐ NO ☐	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? 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

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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.

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

Date and Time of Accident: ____________________ Patient was: Driver____ Passenger____ Pedestrian____

Policy Holder: ____________________

Name of No Fault Carrier: ____________________

Address of Carrier: ____________________

Policy #: ____________________ Claim #: ____________________

Adjustors Name: ____________________ Carrier Phone #: ____________________

Is your No Fault case currently open and active? ______ PIP Deductible (if known) $____________

Are there any benefit limitations? ____ If yes, please describe: ____________________

Attorney's Name: ____________________ Phone # ____________________

Attorney's Address: ____________________

I ____________________ ("Assignor") hereby assign to Advanced Orthopedics ("Assignee") 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 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 AND 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 DOLLARD AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

I hereby authorize the doctor to release information acquired in the course of my examinations or treatments to be released to my no-fault carrier and/or to my attorney.

Patient's Name: ____________________ Patient Signature: ____________________

Patient Address: ____________________ Date: ______________

Provider Name: Advanced Orthopedics, 285 Sills Rd, Bldg 18, East Patchogue, NY 11772

Provider Signature: ____________________ Date: ______________

Advanced Orthopedics

PATIENT INFORMATION

Date ____________ Email ____________

Primary Phone ____________ circle (home/cell) Secondary Phone ____________ circle (home/cell) Work Phone ____________

Name ____________ Last First Middle Social Security No. ____________

Street Address ____________

City ____________ State ________ Zip ____________

Mailing Address (if different) ____________

Sex ☐ Male ☐ Female Age ________ Birth Date ____________ Marital Status ☐ M ☐ S ☐ D ☐ W

Race/Ethnicity ____________ Primary Language ____________

Patient Employer/School ____________ Occupation ____________

Employer Address ____________

Referring Physician or Facility ____________ Address ____________ Phone ____________

Primary Care Physician ____________ Have you obtained a referral from your PCP for this visit? ________

Where did injury occur? ☐ At work ☐ At school/Sport league ☐ Car accident ☐ Slip & fall ☐ Other ____________

In case of emergency who should be notified ____________ Relationship ________ Phone No. ____________

INSURANCE INFORMATION

Person responsible for account ____________ Last First Middle Birthdate ____________

Relationship to patient ____________ Phone No. ____________ Social Security No. ____________

Address (if different than above) ____________

City ____________ State ________ Zip ____________

Responsible party employed by ____________ Occupation ____________

Employer Address ____________ Business Phone No. ____________

Insurance Company ____________

ID No. ____________ Group No. ____________

Cardholder's Name ____________ Relationship ________ Cardholder's DOB ____________

Insurance Company Address ____________ Phone No. ____________

SECONDARY INSURANCE

Insurance Company ____________

ID No. ____________ Group No. ____________

Cardholder's Name ____________ Relationship ________ Cardholder's DOB ____________

Insurance Company Address ____________ PhoneNo. ____________

ASSIGNMENT AND RELEASE

I hereby authorize any insurance benefits to be paid directly to the Physician. I hereby authorize the release of all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges incurred whether or not paid by an insurance company. Interest of 1½ per month (18 annually) may be charged to overdue accounts. Any collection costs (including attorney's fees) will be charged to delinquent accounts and may be reported to credit rating agencies. I realize that insurance assignment (when applicable) is a courtesy extended by Advanced Orthopedics and that I am ultimately responsible for payment of all services rendered. This agreement will remain in effect until revoked by me in writing. A photo copy of this agreement is to be considered as valid as an original.

Signature of Patient ____________ Date ____________
(Parent or Guardian if under 18)

Date ____________ **Advanced Orthopedics**

Name ____________ Birth Date ____________ Age ______ ☐ Male ☐ Female
Height ______ Weight ______ Employer/School ____________ Occupation ____________
The reason(s) for your visit today? ____________
Date of injury? ______ Where did injury occur? ☐ At work ☐ At school/sport league ☐ Car accident ☐ Slip & fall ☐ Other ______
Briefly describe your injury ____________
Were X-rays taken? ______ If yes, where ____________ Do you have them with you? ☐ Yes ☐ No
Referring Physician or Facility ____________ Address ____________ Phone ____________
Your Primary Care Physician ____________ Address ____________ Phone ____________
Are you/have you been treated for this problem by another physician? ☐ Yes ☐ No Physician ____________ Phone ____________
Are you currently working? ☐ Yes ☐ No

Systemic Symptoms
☐Yes Weight change
Other systemic symptoms –
☐No Systemic Symptoms

HEENT Symptoms
☐Yes Headache
Other head related symptoms –
☐No HEENT Symptoms

Neck Musculoskeletal Symptoms
☐Yes Neck pain
Other neck symptoms –
☐No Neck Symptoms

Pulmonary Symptoms
☐Yes Shortness of breath
Other pulmonary symptoms –
☐No Pulmonary Symptoms

Cardiovascular Symptoms
☐Yes Chest pain or discomfort
Other cardiovascular symptoms –
☐No Cardiovascular Symptoms

Gastrointestinal Symptoms
☐Yes Heartburn
Other gastrointestinal symptoms –
☐No Gastrointestinal Symptoms

Genitourinary Symptoms
☐Yes Urine Incontinence
Other genitourinary symptoms –
☐No Genitourinary Symptoms

Skin Symptoms
☐Yes Rashes
Other skin symptoms –
☐No Skin Symptoms

Endocrine Symptoms
☐Yes Excessive thirst
Other endocrine symptoms –
☐No Endocrine Symptoms

Hematological Symptoms
☐Yes Easy bleeding / bruising
Other hematological symptoms –
☐No Hematological Symptoms

Neurological Symptoms
☐Yes Numbness / tingling
Other neurological symptoms –
☐No Neurological Symptoms

Psychological Symptoms
☐Yes Anxiety / Depression
Other psychological symptoms –
☐No Psychological Symptoms

Pain Rating Scale
Please circle the corresponding pain to the primary pain site you are currently having:

0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate pain — Worst possible pain

PAST MEDICAL HISTORY
☐Yes High blood pressure/ Hypertension
☐Yes Diabetes Mellitus
☐Yes Heart Disease (CAD)
☐Yes Heart attack
☐Yes Stroke
☐Yes Asthma
☐Yes Bronchitis
☐Yes Chronic Lung Disease (COPD)
☐Yes Esophageal Reflux (GERD)
☐Yes Peptic Ulcer
☐Yes Blood Clot (DVT)
☐Yes Osteoporosis
☐Yes Arthritis
☐Yes Gout
☐Yes Rheumatoid Arthritis
☐Yes Psoriasis
☐Yes Hepatitis
☐Yes Aids/HIV Infection
☐Yes Cancer
☐Yes Atrial Fibrillation
☐Yes Mitral Valve Prolapse
☐Yes Renal Failure
☐Yes Kidney/Renal Disease
☐Yes Bladder infection/ Urinary Tract infection
☐Yes Sleep Apnea
☐Yes Epilepsy/Seizure
☐Yes Tuberculosis
☐Yes Obesity
☐Yes Scoliosis
☐Yes Thyroid Disorders
☐Yes Hemophilia
☐Yes Fibromyalgia
☐ No Active Problems
Other past medical history:

RELEVANT HISTORY
☐Yes Currently pregnant?
☐Yes Are you taking blood thinners?
☐Yes Past reactions to anesthesia?

PAST SURGICAL HISTORY
List past surgeries and dates –

FAMILY HISTORY
☐Yes Cancer
☐Yes Heart Disease
☐Yes High blood pressure/ Hypertension
☐Yes Autoimmune Disease
☐Yes Osteoarthritis
☐Yes Diabetes Mellitus
☐ No significant family history of disease

SOCIAL HISTORY
☐Yes ☐No Smoker –
If yes: ___ packs/day x ____ years
☐Yes ☐No Alcohol –
If yes: ☐ Less than 2 drinks/day
☐ 3 or more drinks/day
☐Yes ☐No Drug Use –
If yes: specify ______

Office Use Only

Signature of Patient ____________ Date ____________

ADVANCED ORTHOPEDICS

Patient Name: ____DOB: ________________

Pharmacy Information

Please list your pharmacy information so that we may electronically prescribe medications for you, when possible:

Pharmacy Name: ______________________________ Phone#: ____________________

Address:____

***If you do not indicate a preferred pharmacy, we will automatically send your electronic prescription to: Sunrise Pharmacy, located at 285 Sills Rd, Building 8B, in East Patchogue.**

Current Medications

Please list ALL of the medications you are currently taking:

Medication Name	Strength	Dosage/Day

Allergies

Please list ALL allergies (drug, food, environmental):

Allergen	Reaction(rash, nausea, shortness of breath, etc)

Signature of Patient____Date________________

(Parent or Guardian if under 18)

ADVANCED ORTHOPEDICS

285 Sills Rd, Building 18, Patchogue, NY 11772
31 Main Rd, Suite #3, Riverhead, NY 11901
2500 Nesconset Hwy., Building 20-A, Stony Brook, NY 11790

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities may include, but are not limited to, quality assessment, employee review, training, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at

any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information:

You have the right to inspect/receive a copy of your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ADVANCED ORTHOPEDICS

285 Sills Rd, Building 18, Patchogue, NY 11772
31 Main Rd, Suite #3, Riverhead, NY 11901
2500 Nesconset Hwy, Building 20-A, Stony Brook, NY 11790

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

______________________________ ______________
Patient Name or Legal Guardian (print) Date

____
Signature

You may choose up to 2 people (such as a relative, friend, and/or attorney) to share your medical information with. Any future requests to change this information, must be submitted in writing.

My protected health information may be released/discussed with the following persons:

Name:______________ Relationship:__________ Phone:__________

Address:______________________________

Name:______________ Relationship:__________ Phone:__________

Address:______________________________

Signature of Patient/Legal Guardian:______________________________

Print Name of Patient/Legal Guardian:______________________________

Office Use Only

We have made the following attempts to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

*Date(s):*______________________________

*Attempt(s):*______________________________

*Staff Name(s):*______________________________

Advanced Orthopedics Financial Policy

Thank you for choosing Advanced Orthopedics as your orthopedic care provider. We are committed to providing you with the highest quality care at a reasonable cost. Acknowledgement and understanding of our Financial Policy must be signed prior to treating with our providers. Your clear understanding of our Financial Policy is important to our professional relationship as it may avoid unnecessary billing issues that may happen as a result of incorrect insurance information and misunderstanding. Please ask if you have any questions at all.

INSURANCE: Advanced Orthopedics will file claims to your insurance company. It is the responsibility of the patient to know what your coverage, benefits, and eligibility is. Your insurance carrier makes the final determination regarding eligibility and coverage. You agree to pay any portion not covered by your insurance. Insurance changes must be brought to our attention immediately as the patient will be responsible for all charges not paid as a result of change in insurance coverage.

SELF-PAY PATIENTS: All Self-Pay patients and patients who present without proof of insurance are required to pay for their services on the day of visit. Payment plans may be made and a separate agreement will be provided.

FORMS OF PAYMENT: We accept Cash, Checks, Visa, MasterCard, Discover, American Express and CareCredit.

CO-PAYMENTS: If your coverage requires a patient co-pay, we are obligated by your insurance carrier to collect this at the time of service. Failure to collect co-pays puts both the patient and Advanced Orthopedics in default of the insurance contract. Please be prepared to pay the co-pay at each visit. **Without it, you may be required to reschedule.** There will be a $10 processing fee for any unpaid co-pay. Chronic non-payment may constitute dismissal from the practice. Some insurance carriers impose more than one co-pay for each visit, e.g. a co-pay for an office visit plus a co-pay for an xray. We may not be aware of your insurance carrier's multiple co-pay policy, and therefore, may bill you for any uncollected co-pay at a later time based on the Explanation of Benefits from your insurance.

DEDUCTIBLES: If your coverage includes a patient deductible, you may be asked to pay a portion of your unmet deductible at the time of service. Patients with very high unmet deductibles will be asked to remit a minimum of $250 at your first visit as a deposit and any remaining balance will be billed upon receipt of the insurance carrier's Explanation of Benefits.

REFERRALS: If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment or prior to. If you do not have your referral, you may have to reschedule your appointment or be considered a Self-Pay patient.

NON-PARTICIPATING INSURANCE PLANS or "OUT OF NETWORK": In accordance with a recent law, providers are required to make every effort to inform patients if they may be receiving services Out-of-Network by a non-participating provider. We may provide you with an additional consent form to complete if seeking care from an Out-Of-Network provider. You must also be aware of your own insurance benefit. When in doubt, contact your insurance company directly for clarification. You are responsible for care not covered by your out-of-network insurance plan. Patients treated by any physician, provider or physical therapist at Advanced Orthopedics who do not participate in your insurance plan, are directly responsible for the charges which may not be reimbursed by insurance. We cannot waive copayments, deductibles, coinsurance or other amounts that you responsible to pay under your health plan.

You may also request the estimated charge(s) for expected services. You understand that this is only an estimate and is not a guarantee. Your actual out-of-pocket costs will depend on your eligibility, how much of your annual deductible has been met when the claim is received, the actual services received, the procedure codes submitted by us, your cost-sharing requirements (deductible, coinsurance), or other variables that may impact the cost of services, including a need for additional or different services than originally expected or unanticipated complications. If you have a secondary insurance, or a supplemental accident insurance policy is involved (such as school accident insurance), your secondary insurance coverage will be billed and will most likely further reduce your estimated patient liability or out of pocket expenses.

FEES: Advanced Orthopedics uses "Reasonable and Customary" fees, specifically the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by FAIRHealth, a nonprofit organization specified by the NYS Superintendent of Financial Services.

NO-FAULT/WORKERS COMP CASES: Patients must report the complete circumstances of the motor vehicle accident or Workers Compensation incident to the front desk staff and complete the appropriate form indicating the date of injury, claim number, insurance company name and address, phone, #, and contact person's name prior to receiving services. We must verify your

insurance claim is open and active for the injury you are being treated for prior to services being started. If the insurance denies the claim and you have private health insurance, it must be billed.

ACCIDENT/SLIP AND FALL/SCHOOL INJURY/SPORTS LEAGUE CASES: Patients shall be financially responsible for medical services related to slip and fall, accidents, and school injury or sports league cases. Patients must report the circumstances to the front desk staff and complete the appropriate form indicating the date of injury, claim number, insurance company name and address, phone, #, and contact person's name prior to receiving services. If the insurance denies the claim and you have private health insurance, it must be billed. For school or sports league injuries, the patient's private insurance must be billed as primary, except for Medicaid policies. Therefore, private health insurance information must also be provided before services are rendered. If they do not pay, the patient is responsible for provider's full charges. Liens will not be accepted.

NO-SHOW APPOINTMENTS: Missed appointments or No-Shows represent a cost to us, you and to other patients who could have been seen in the time set aside for you. There is a $25 fee for any broken appointments not cancelled within 24 hours. Missed MRI appointments will incur a $50 fee and patients who fail to report for scheduled surgery at the hospital will be assessed a $250 fee if 24 hours' notice is not provided to the office. Patients with multiple missed appointments of any type may be discharged from the practice.

RETURNED CHECK FEES: Any returned check from the bank for non-payment or insufficient funds shall result in the patient's account being assessed a $30.00 fee per check returned.

CHILD CUSTODY CASES and SECOND PARTY INSURANCE: In the case of divorce or separation, the parent authorizing treatment for a child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect reimbursement from the other parent.

MINORS: Minors under the age of 18 MUST be accompanied by a parent or legal guardian for all services.

FRACTURE CARE/INJECTIONS/ASPIRATIONS: Some insurance companies require that fracture care and injection/aspiration billing be performed on a "global" basis. This means that for a pre-determined amount of time, anywhere from 10-90 days, most professional services related to the fracture care or injection/aspiration, are classified by insurance carriers as "surgery", and are included in the initial service. X-rays, injections, aspirations, unplanned casting/splinting, and supplies, are not included within the global fee and are billed separately and any applicable patient out-of-pocket expense including copays and deductibles will be due. Please note that some insurance companies require each visit to be billed separately rather than global billing. Injections, aspirations and fracture care are all procedures listed as "surgical" for billing purposes by insurance companies. Although these services may be provided in the office or emergency room, they may appear on your explanation of benefits as "surgical".

OUTSTANDING BALANCES: If you have any outstanding self-pay or insurance designated outstanding balances for co-pays, deductibles and other unpaid out-of-pocket expenses, you will be asked to remit payment at your next visit or you may be required to reschedule your appointment. Chronic non-payment of bills can constitute seperation from the practice.

COLLECTIONS: If your balance is not paid within 60 days, the account may be forwarded to a collection attorney. Please understand, we do not handle the accounts from this point forward. Their methods are their own, and in addition to the uncollected balance you will be required to pay any fees associated with collections, including interest and court costs.

THIRD PARTY INSURANCE FORMS (DISABILITY, FMLA ETC): Your employer, insurance carrier, accident/sickness insurance, etc. may ask you to complete a disability, FMLA, or other form which requires information regarding your care from your physician. A $15 charge per form is required prior to completion. Please allow up to 10 business days for form completion.

MEDICAL RECORDS: Written authorization for release of your medical records is required. Medical record processing is performed by an outsourced company, HealthPort. Once a medical record authorization request is received, HealthPort will send the patient a bill for the copying and mailing of the records prior to releasing records. The law allows up to 30 days to process all medical record requests, however, requests are processed as soon as they are received and usually do not take more than 10-14 days.

I have read the Financial Policies of Advanced Orthopedics and agree to comply with the Financial Polices. In addition, Advanced Orthopedics has my permission to provide medical documentation in order to obtain reimbursement.

______________________________ _______________

Printed Patient Name Date

______________________________ _______________

Patient Signature (or Parent or Legal Guardian) Date

Advanced Orthopedics

Out of Pocket Credit Card Expenses

Date: ______________ Responsible Party: ____________________

Patient Name: ____

Address: ____

____

Home Telephone #: __________________________ Cell #: __________________________

I understand that I am directly responsible for my Out-of-Pocket expenses, including any unmet deductible, coinsurance, copayment, or non-covered services. I authorize Advanced Orthopedics to charge my credit card per my insurance carrier's explanation of benefits for any Out of Pocket Expenses.

I certify that this is my credit card and I am legally authorized to give permission for its use.

This authorizes ONLY Advanced Orthopedics to place charges on my account.

Name on Credit Card: _________________________________

Card Holder Address: ____

____

Credit Card Number: ______________________________________

Circle: Visa MasterCard American Express Discover

Exp: ____________ Billing Zip: ___________________ Security Code: __________

Is this a Medical Savings Account, HSA, or HRA? ___Yes ___No

Signature: ____

Printed Name: ____

FOR OFFICE USE ONLY

Staff Signature: _______________ Acct #: ____________________ Date: ________________