WORKERS' COMPENSATION REGISTRATION FORM

Referring Physician:________________________

Referring Physician Phone#:__________________

1. Carrier Case#:________________________ WCB#:________________________________
2. Last Name:______________________________ First Name:__________________________
3. Social Security#: ________________________Date of Birth: _____________ Gender: M F
4. Street Address: _________________________________ City: __________________________
5. State: ___________ Zip: ______________ Home Phone#: ____________________________
6. Cell Phone#: ______________________
7. Date of Injury/onset of illness: ____________________ Body Part: ______________________
8. On the date of injury/illness what was the patient's job title: ____________________________
9. Briefly describe how and where injury occurred: ____________________________________
   ____
10. Are you presently working? Yes____ No____ If 'No' when did you stop? ________________

    If 'Yes', are you on Regular Duty? __________ Light Duty? ______________________

    If you stopped, when did you return? ______________________________________
11. Employer at time of injury:____

    Employer Address:_________________________________ City:________________

    State: ____________ Zip:_____________ Employer Phone:____________________

    Contact: _____________________________
12. Employer's WC Insurance Carrier: ____

    Carrier Address: ______________________________ City: ______________________

    State: ___________ Zip: _______________ Adjuster Name: _____________________

    Adjuster Phone#: _______________________________

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case, I hereby agree to pay (Physician Name) ______________ the usual and customary fees for services rendered to the above claimant. I authorize the provider to release any information necessary to substantiate a claim.

Signature: _____________________________________ Date: ____________________

St.Charles Orthopedics

INITIAL VISIT HISTORY FORM

Name:________________________________ Date:__________ Social Sec.# ____________________

Phone:________________ Age:______ DOB:__________ Sex: M / F

Name of your Primary Care Doctor:____

Were you referred by a physician? Y / N: Name ________________________________ Phone: ____________________

Reason for today's visit: (briefly state history of problem and when symptoms began)

____

____

Problem due to: (check) ____ car accident ____ work-related ____ school injury ____ other

Past Medical History: Have you ever had any of the following medical problems?

Yes	No		Yes	No		Yes	No	
__	__	Stroke	__	__	Cancer	__	__	Thyroid Disease
__	__	Ulcers	__	__	Hepatitis	__	__	Rheumatoid arthritis
__	__	Colitis	__	__	Diabetes	__	__	High Blood Pressure
__	__	Asthma	__	__	Tuberculosis	__	__	Nervous Disorder
__	__	Lyme Disease	__	__	Heart Disease	__	__	Bleeding Disorder
__	__	Arthritis	__	__	Kidney Stones	__	__	Endocrine problems

Explain any positive responses above (and other medical problems not listed): ________________________

____

Past Surgical History: (list all surgeries) ____

____

Medications (list): ____

____

Allergies (medicines): ____

____

Review of Systems: Are you having problems with any of the following?

Yes	No		Yes	No		Yes	No	
__	__	Eyes	__	__	Psychiatric problems	__	__	Digestion/Bowel Movement
__	__	Ears, nose, throat	__	__	Joint pain	__	__	Stomach burning
__	__	Lungs/breathing	__	__	Immune system	__	__	Cardiovascular problems
__	__	Recent weight loss	__	__	Urinary problems	__	__	Hematologic/bleeding problems
__	__	Weakness/fatigue	__	__	Chest pain	__	__	Neurologic problems

Explain positive responses: ____

____

Family Medical History: List medical problems of your relatives (ex. Diabetes, cancer):

Grandparents:____

Mother:__________________________ Father:_______________________________

Siblings:____

Children:____

Social History: Occupation:________________________ Working now? Yes / No / Retired

Do you smoke: Yes /No / Quit? Packs per day: ___ If Quit, years smoked: ___ yrs.

Alcohol use (circle one): Never / Occasional / Daily / Heavy / History of alcoholism

Any history of Drug use (list): ____________________________________

(circle one) Married / Single / Divorced / Widowed Live Alone? Yes / No

Are you on a special diet? ______________________________________

Do you exercise / play sports (describe briefly)? ___________________________

Completed by: (sign)________________________ Reviewed by: Dr. ____________________

Office Use Only ----------- H: ______ W: ______ T: ______

Revised 5/13

St Charles Orthopedics

INITIAL VISIT

Patient's Name:____

Patient's DOB:____________________ Date:________________________

Employer:_______________________Job Title:________________________

Job Description:____

1. How did injury occur? Give source of information. If an occupational disease, include history and date of onset of related symptoms.

2. If there is any history or evidence of pre-existing injury, disease or physical impairment, describe specifically.

3. Has patient reached maximum medical improvement? If no, when will patient be seen again?

4. Describe treatment rendered and planned future treatment.

5. May this injury result in permanent restriction, total or partial loss of function of a part or member, or permanent facial, head or neck disfigurement?

   YES or NO

6. First date of disability, if known: ______________________________

7. Is patient working? **YES or NO**

8. Is patient disabled from regular duties at work? **YES or NO**
   If **YES**, disability is: **TOTAL or PARTIAL**

   If **PARTIALLY DISABLED**, what are the exact job limitations?

9. Was the occurrence or occupational history described above (or in your previous report which gave this information) the competent producing cause of the injury or disease and disability (if any) sustained? **YES or NO**

(rev. 3/15/16)

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS APT. NO.
EMPLOYER		
INSURANCE CARRIER		

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature______________________________ Date ______________

Provider's Name and Address ______________________________________

____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

St.Charles Orthopedics

unparalleled skill compassionate care

ACCEPTANCE OF FINANCIAL RESPONSIBILITY WORKERS COMPENSATION/NO FAULT

Patient: ____________________________________

Guarantor: ____________________________________

NF/WC Carrier: ________________________________

Private Insurance: ______________________________

In the event that my Workers Compensation/No Fault carrier does not authorize payment to Dr. ____________________, you may bill my private insurance carrier for payment.

If my private carrier requires a referral and I do not have one for today's visit, I agree to be responsible for all charges. (You are urged to get a referral to cover this and other visits).

If I do not have private insurance or my private insurance denies this claim, I will be held responsible for any fees for office visits and diagnostic testing.

Signed: ______________________________ Date: ________________
Patient/Guarantor

Witness: ____________________________

6 Technology Drive, Ste. 100 • East Setauket, NY 11733 •(631) 689-6698 •(631) 751-5548
Offices in East Setauket, Wading River, Riverhead, Southampton, Patchogue, Commack, West Babylon

DATE________________________________

To Whom It May Concern:

I, ____________________________________, authorize St Charles Orthopedics to disclose to the Ombudsman for the Medical Society of the State of New York information about my medical claim(s) for health plan benefits in relation to care provided by Dr. _______________________ stemming from services rendered between ______________________ and continuing through _____________________. This authorization will be considered valid until the medical bills for care provided to me by Dr. ____________________________ have been satisfactorily resolved.

Your attention and cooperation in this matter is appreciated. It is requested that the attached data be given expedited handling.

Sincerely,

____

(Patient's Signature)

Please ONLY fill out:

1. **Date**
2. **Print your name in the blank under Date**
3. **Sign your name at the bottom**

We will fill out the rest of this form.

Thank you

St.Charles Orthopedics

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

Signature of Patient or Personal Representative ____________________

Print Name of Patient or Personal Representative ____________________

Description of Personal Representative's Authority ____________________

Date ____________________

Signature of Facility Representative ____________________

Date ____________________

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. St. Charles Orthopedics may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit St. Charles Orthopedics to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

____________________ ____________________ (Relationship to patient)

____________________ ____________________ (Relationship to patient)

I expressly permit St. Charles Orthopedics to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel. # ____________________

Office voicemail: Tel. # ____________________

Other (specify): Tel. # ____________________

Signature of Patient / Personal Representative
Parent/Guardian ____________________

Date ____________________

ST. CHARLES ORTHOPEDICS
FINANCIAL POLICY

Thank you for choosing Orthopedic Associates of Long Island, LLP! We are committed the success of your medical treatment and care. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you have any additional questions about any of these policies, please ask to speak with a Billing Specialist.

Which Plans Do You Contract With?

Your physician/surgeon and their assistant(s) may not be an in-network provider with your health care insurance plan. Please check our website, www.stcharlesorthopedics.com, to check physician insurance participation and hospital
affiliation. If you have any questions, you can contact our billing department to obtain details about your surgery or office visit including the estimated amount of money you may be responsible for paying.

When Do I Pay?

Payment is expected for all copays at the time of the visit. If you do not have insurance or you are covered by an insurance company with which we do not participate, all fees must be paid at the time of visit. We accept payment by cash, Check, VISA, Mastercard, American Express and Discover.

Do I Need A Referral?

If you have a managed care plan with which we are contracted, you may need a referral from your primary care physician. If we have not received a referral prior to your arrival at the office, there will be a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or offered an opportunity to assume financial responsibility for the services provided that day.

What If My Child Needs To See The Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account. Any issues of payment resulting from separation or divorce documents must be resolved by the parents. We will hold the accompanying adult responsible for all charges unless specific arrangements have been made.

What Is My Financial Responsibility For Services?

Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services
HMO & PPO plans which have a contract

If the services are covered by the plan: All applicable copays are due at the time of the office visit. We ask for immediate payment as soon as any deductible is known. If the services you receive are not covered by the plan: Payment is expected in full at the time of the visit. You will be asked to sign a statement authorizing these services.

HMO with which we are not contracted

Payment in full for office visits, x-rays, injections, and all other charges is expected at the time of the office visit. We will provide the necessary information for you to complete and file your claim directly with the insurance company.

Point of Service Plan or Out of Network PPO

Payment for the copay and non-covered services is expected at the time of visit. We will file an insurance claim on your behalf. Coinsurance and deductibles will be billed after we receive payment from your carrier. All balances due will be payable upon receipt of our statement.

Patient Name________________________________ Date of Birth____________________

Medicare (also Medicare HMO Plans)
We will file the claim on your behalf, as well as any claims to your secondary insurance. Payment for copays or any Services not covered by Medicare must be paid at the time of the visit. If you have regular Medicare as primary, and also have secondary insurance, copay will be collected depending on secondary plan. If you have regular Medicare as primary, but no secondary insurance, payment of your 20% coinsurance will be collected at the time of the visit. If Medicare is secondary, you will be billed for any patient responsibility after both insurances have processed.

Worker's Compensation
Prior to your visit, you will need to provide the accident date, claim number, employer information and insurance carrier information. If we have verified the claim with your carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and payable at our usual and customary fees.

Worker's Compensation (Out of State)
Payment in full is requested at the time of then visit. We will provide you a receipt so you can file the claim with your carrier.

Automobile No-Fault Insurance
Prior to your visit, you will need to provide the accident date, claim number and the insurance carrier information. If the No Fault policy is not in your name, we will need full information on the policyholder.
If we have verified the claim with the carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and is payable at our usual and customary fees. **If a referral is needed from your private carrier, you must obtain one in the event that your no-fault carrier denies your claim.**

Commercial Insurance: Also known as indemnity, "regular" insurance, or has a percentage coverage (eg. "80/20% coverage".)
We will file a claim to your insurance company as a courtesy. In the event of a denial of any part of the claim, you will need to pay this bill and deal with your insurance carrier directly.

School Insurance: You must submit the original form from the school's carrier. Please bring a copy of the form with you. If you do not have any other insurance, we will bill the school insurance directly. If you have other insurance, the school insurance is secondary and while we will file the claim with your school carrier, you are responsible for payment.

No Insurance (Self Pay)
Payment in full is due at the time of the visit. We will work with you to settle your account. Please ask to speak with our staff if you need assistance.

SURGERY
If your physician recommends surgery, you will have the opportunity to speak with his executive assistant. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. If you have a commercial plan or are self-pay, she may request a pre-surgical deposit.

Updated 5/19/15

Patient Name______________________________ Date of Birth____________________
Signature_________________________________ Date____________________

Catholic Health Services

Patient Authorization, Assignment of Benefits & Financial Agreement

Patient Name_______________________ Date of Birth___________________ Effective Date: 01/01/2016

I acknowledge and understand that by signing below, I hereby authorize payment directly to ST. CHARLES ORTHOPEDICS 6 TECHNOLOGY DRIVE, SUITE 100 EAST SETAUKET, NY 11733 www.stcharlesorthopedics.com for services rendered to me, as specified more fully below.

1. **MEDICARE:**
   - I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
   - I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
   - I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
   - The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
   - I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
   - My authorization will remain in effect unless I revoke my authorization in writing.

2. **OTHER INSURANCE PLAN PARTICIPATION:** The Practice maintains a list of its contracts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the Practice at the address, telephone number and/or website listed above.
   - I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
   - I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
   - I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

3. **NON-COVERED SERVICES:** I understand that each Plan (*i.e.*, HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.
   - I understand that I will receive an Advanced Beneficiary Notice ("ABN") from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
   - I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
   - I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

4. **RELEASE OF INFORMATION:**
   - I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
   - I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to State or Federal law.

5. **FINANCIAL AGREEMENT:**
   - In return for the services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
   - If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
   - If my account is delinquent, I may be charged interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
   - If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayment and/or deductible amounts to the Practice.
   - ***I agree to be primarily responsible for the payment of the Practice's bill.***

_______________________________________ ______________________

Beneficiary Signature or Authorized Party Date