COMPREHENSIVE SPINE CARE, P.A.
PATIENT INFORMATION

Patient's Name ____

Address ____

Home # ________________ Cell # ______________ Work # ____________________

Email Address ____

Sex: ____ Male______ Female Marital Status ______________________________

Date of Birth______________ Social Security #______________________________

Employer's Name ________________________Occupation____________________

Who referred you to our office? _______________________

Is today's visit related to an **Auto Accident** or **Work Injury** (circle one)

Are you currently working? (circle one) **YES** or **NO** / Out of work since: DATE: ____________

INSURANCE INFORMATION

Name of Insured__________________________ SS # of insured__________________

Name of Primary Insurance Co.__________________ Phone #______________________

Address of Carrier____

Insurance ID#________________ Group#______________________________

Subscriber Sex:_____ Male ______Female Subscriber Date of Birth__________________

Relationship to patient:____

SECONDARY INSURANCE

Name of Insured_______________________ SS # of insured______________________

Subscriber Date of Birth___________ Sex: Male/Female Relationship to patient________________

Insurance Carrier________________Address______________________________

Insurance Phone #__________ Insurance ID#______________ Group #__________________

Emergency Contact: Name____________________ Phone#________________________

Relationship to Patient______________________________________

Address______________________________________

PHARMACY NAME: ___________________________Phone#______________________

Address______________________________________

COMPREHENSIVE SPINE CARE, P.A.

WORKERS COMPENSATION- EMPLOYEE ACCIDENT FORM

<table>
<tr><td rowspan="2">Patient's Name:</td><td colspan="2">Date of Birth:</td></tr>
<tr><td colspan="2">Sex: Male OR FEMALE</td></tr>
<tr><td>Employer name:</td><td>Date of Accident:</td><td>Time of Accident:</td></tr>
<tr><td>Workers Compensation Insurance:</td><td colspan="2">Claim #:</td></tr>
<tr><td colspan="3">Please describe why you are here:</td></tr>
<tr><td colspan="3">Please describe how your got hurt and when the injury occurred:</td></tr>
<tr><td colspan="3">Where are you feeling pain? Please describe:</td></tr>
<tr><td colspan="3">Previous Workers Compensation Claims: YES or NO Date of Accident:
Please describe:</td></tr>
<tr><td colspan="3">Have you ever been treated for this issue in the past or something similar? If yes, please provide name of the physician who treated you.</td></tr>
<tr><td colspan="3">Please list any medications you are taking for this condition or injury.</td></tr>
<tr><td colspan="3">Have you ever been in a motor vehicle accident (MVA)? YES or NO

If yes, please provide date of MVA and details of injury:</td></tr>
<tr><td colspan="3">Have you ever seen a Chiropractor? YES or NO
If YES:
Name: Address: Date:</td></tr>
<tr><td rowspan="2">Name of Primary Care Provider (PCP):</td><td colspan="2">Address:</td></tr>
<tr><td colspan="2">Phone #:</td></tr>
<tr><td colspan="3">Have you ever received pain management treatment? If yes, please provide name of physician and time frame of treatment.</td></tr>
<tr><td colspan="3">Are you involved in any recreational or sporting activities? If yes, please describe….</td></tr>
<tr><td colspan="3">I CERTIFY THAT THE ABOVE ANSWERS MADE BY ME ARE CORRECT.</td></tr>
</table>

Patient Signature: Today's Date:

COMPREHENSIVE SPINE CARE, P.A.

COMPREHENSIVE PHYSICAL THERAPY

Nomaan Ashraf, M.D.
Board Certified Adult & Pediatric Spinal Surgery

RAFAEL LEVIN, M.D.
Board Certified Adult & Pediatric Spinal Surgery

JONATHAN P. LESTER M.D.
Board Certified Adult Physical Medicine & Rehabiilitation

JAY GREENSPAN, PT, CERT, MDT
Physical Therapy

PATIENT'S NAME____

INSURANCE AUTHORIZATION AND ASSIGNMENT (please read and sign)

The patient is responsible for all fees, deductible and co-payments regardless of insurance coverage unless forbidden by prior insurance contracts. You are expected to pay for services at time they are rendered unless arrangements have been made in advance.

I hereby authorize payment to Comprehensive Spine Care, P.A./Comprehensive Physical Therapy of any benefits otherwise payable to me for their services.

I hereby authorize Comprehensive Spine Care, P.A./Comprehensive Physical Therapy to receive and furnish to insurance companies, their representatives or designated attorney and requesting physicians, any information concerning my treatment.

I hereby assign to Comprehensive Spine Care, P.A./Comprehensive Physical Therapy all payments for medical services rendered to my dependants or myself. I agree that if my insurance company sends me a check for services rendered by Comprehensive Spine Care, P.A./Comprehensive Physical Therapy to my dependants or me, I will enclose this check and forward it to Comprehensive Spine Care, P.A./Comprehensive Physical Therapy within 5 days.

If any collection proceedings are required to cover any outstanding balance, I understand I will be responsible for said costs including attorney fees of 33.3% of the unpaid balance. These costs are above and beyond for services rendered.

Comprehensive Spine Care, P.A./Comprehensive Physical Therapy reserves the right to charge 1.5% interest per month on any balance that remains after 60 days.

SIGNATURE OF PATIENT____________________________________ DATE____________________

SIGNATURE OF INSURED____________________________________ DATE____________________

466 OLD HOOK ROAD, SUITE 16, EMERSON, NJ 07630, TEL # 201-634-1811, FAX # 201-634-9170
MAILING ADDRESS: P.O. BOX 631, WESTWOOD, NJ 07675
www.compspinecare.com

COMPREHENSIVE SPINE CARE, P.A.

COMPREHENSIVE PHYSICAL THERAPY

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FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below.

1. My authorization applies to the information described below. Only his information may be used and/or disclosed pursuant to this authorization.

   _______All information/no restrictions
   _______Restrictions as listed____
   ____

2. I authorize the following persons (or class of person) to make the authorized use and/or disclosure of my protected health information.

   _______Physician: Ari Ben-Yishay, M.D., Rafael Levin, M.D., Nomaan Ashraf, M.D., Jonathan Lester, M.D., Jay Greenspan, PT, CERT, MDT
   _______Physician Staff: Medical Assistant, Receptionist, Biller, Collectors, Physical Therapist

3. I authorize the following persons (or class of persons) to receive my protected health information.

   _______Family (please list names)____
   _______No Fault Carriers (Automobile) and adjustors associated with No Fault (automobile)
   _______Medical Insurance Company
   _______Workers Compensation including adjusters and case managers associated with my case and any insurance claim review companies associated with Workers Compensation insurance.
   _______Employer____

4. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

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6. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

7. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons that I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

8. This authorization expires upon 3 years after my last treatment by Comprehensive Spine Care, P.A. and /or Comprehensive Physical Therapy.

9. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Comprehensive Spine Care, P.A., nor will it affect my eligibility for benefits.

10. My protected health information will be used or disclosed upon request for the following purpose.
    - Obtaining authorization for treatment
    - Disability (with proper authorization)
    - Scheduling treatment (hospital, outpatient facility, physical therapy facility, pain management facility, diagnostic facility)
    - Social Security (with proper authorization)
    - Collecting payment for medical services
    - Attorney (when appropriate authorization from attorney is received)
    - Billing for medical services
    - Referral to other physicians by Comprehensive Spine Care, P.A.

11. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed.

12. Changes to the above document must be submitted in writing to Comprehensive Spine Care, P.A. Changes will be effective immediately upon receipt of request.

By signing this form, you are granting consent to Comprehensive Spine Care P.A. and/or Comprehensive Physical Therapy to use and disclosure your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed

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information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling 201-634-1811.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_______________________________ ___________________________
Signature Date

____
Name

_______________________________ ___________________________
Name of personal representative Relationship to patient

If you have any questions, please feel free to speak to any of the staff members.

Thank you,

Comprehensive Spine Care, P.A
Comprehensive Physical Therapy

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PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ____________________________ DOB: __________________

I hereby authorize the release any and all of my medical records to Comprehensive Spine Care, P.A. if requested for the purpose of continued care, insurance, legal or personal reasons.

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication.

Signature: ____

Today's Date: ____

Updated 8.7.17

COMPREHENSIVE SPINE CARE, P.A.

NAME_____________________________________ DATE_________________________

PLEASE CHECK ALL POSITIVE CONDITIONS

- **General:** ____Fever ____Chills ____Unexplained weight loss ____Cancer
- **Eyes:** ____Glaucoma ____Blurred Vision ____Other_____________
- **Cardiac:** ____Shortness of Breath ____Chest Pain ____Irregular heart beat
  ____Palpitations ____High Blood Pressure ____Other____________
- **Vascular:** ____Swelling of feet and ankles ____Other_____________
- **Neurologic:** ____Frequent Headaches ____Seizures ____Double Vision
  ____Ringing in ears ____Dizziness ____Other_____________
- **Urinary:** ____Frequent urination ____Hesitancy ____Blood in urine
  ____Painful urination ____Kidney Disease
- **Gastrointestinal:** ____Nausea ____Vomiting ____Blood in Stool ____Heartburn
  ____Ulcers ____Other_______________
- **Respiratory:** ____Shortness of Breath ____Wheezing ____Coughing
  ____Asthma ____Other______________
- **Musculoskeletal:** ____Arthritis ____Joint Swelling ____ Other
  ____Back Pain ____Neck Pain
- **Endocrine:** ____Thyroid Abnormalities ____Cold or Heat Intolerance
  ____Diabetes ____Other_________________
- **Skin:** ____Rashes ____Other_______________
- **Blood:** ____Anemia ____Easy bruising or bleeding ____Past blood transfusion
  ____Other______________________

ALL SYSTEMS ARE NEGATIVE: **YES** **NO**

PATIENT SIGNATURE:____

COMPREHENSIVE SPINE CARE, P.A.

DATE____________________**NAME**____________________________________**SEX**______**AGE**_______

HEIGHT___________ **WEIGHT**____________ **DATE OF BIRTH**_______________________

SMOKER: YES NO AMOUNT PER DAY______ **ALCOHOL:** YES NO HOW OFTEN______

MEDICAL HISTORY:	YES	NO	**FAMILY:** YES	NO
DIABETES	___	___	___	___
CANCER	___	___	___	___
HIGH BLOOD PRESSURE	___	___	___	___
ASTHMA	___	___	___	___
KIDNEY DISEASE	___	___	___	___
ULCERS	___	___	___	___
ARTHRITIS	___	___	___	___
DEPRESSION	___	___	___	___

ALLERGIES:	YES	NO	**NAME OF DRUG**	**REACTION**
ANTIBIOTICS	___	___	___________________	___________________
SHELLFISH/IODINE	___	___	___________________	___________________
MEDICATIONS	___	___	___________________	___________________
ANESTHESIA	___	___	___________________	___________________

MEDICATIONS PRESENTLY TAKING: ____

PAST SURGICAL PROCEDURES AND DATE: ____

COULD YOU BE PREGNANT TODAY? ____

FAMILY PHYSICIAN: ____________________ **ADDRESS:** ________________________ **PHONE:** ________

FAMILY HISTORY:	**ALIVE/WELL** (NUMBER OF EACH)	**DECEASED** (NATURE OF DEATH)
PARENTS	___________	___________
SIBLINGS	___________	___________
CHILDREN	___________	___________

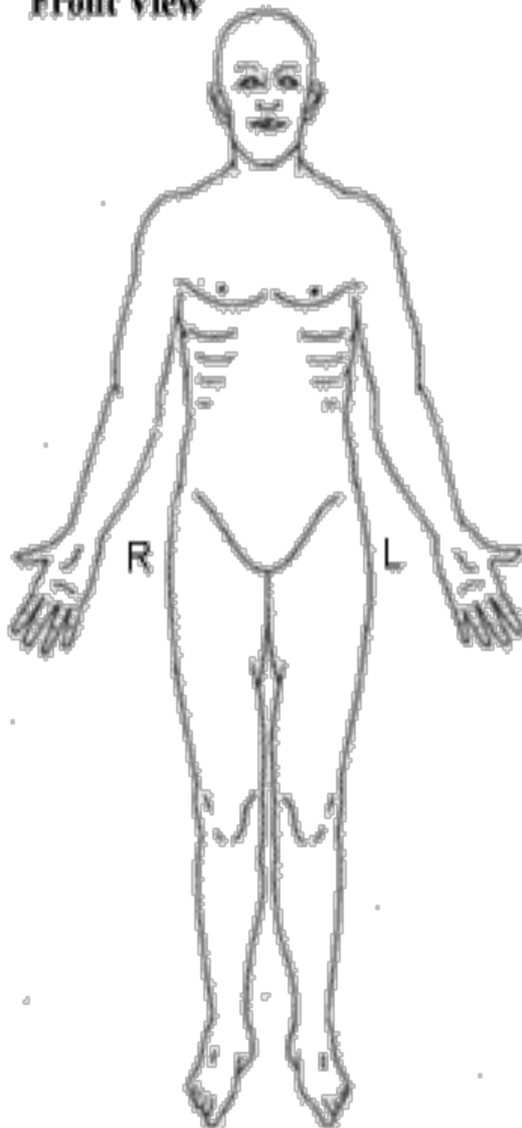
COMPREHENSIVE SPINE CARE, P.A.

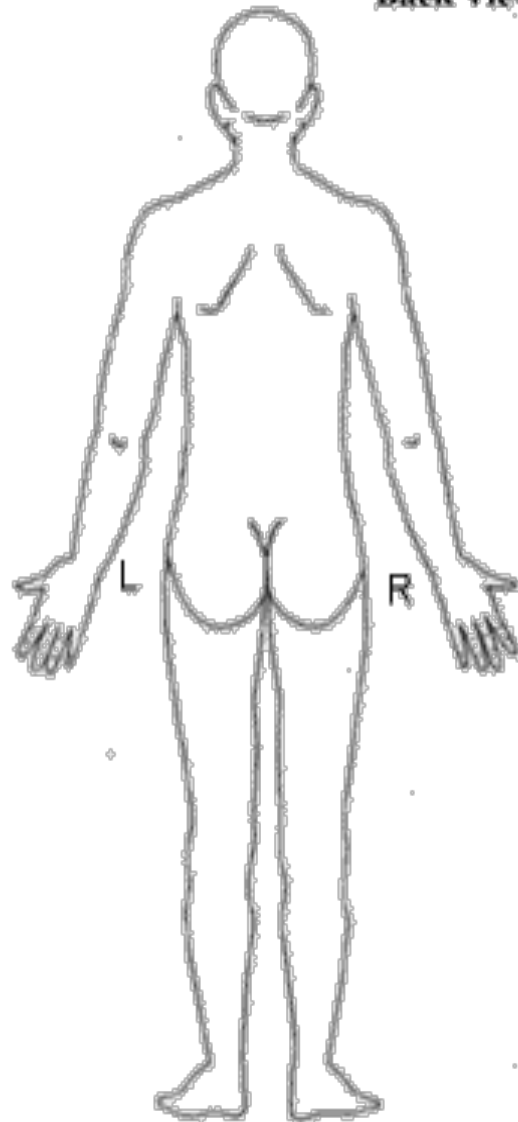
NAME____ DATE____________________

WHERE IS YOUR PAIN NOW?

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
AAA	**OOO**	**----**	**XXX**	**IIII**
AAA	**OOO**	**----**	**XXX**	**IIII**
AAA	**OOO**	**----**	**XXX**	**IIII**





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SUBSTANCE REPORT

Name: ____

Mark each box that applies

Family History of Substance Abuse	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
Personal History of Substance Abuse	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drug	[ ]
History of Preadolescent Sexual Abuse		[ ]
Psychological Disease	Attention Deficit Disorder	[ ]
	Obsessive Compulsive Disorder	[ ]
	Bipolar, Schizophrenia, Depression	[ ]

Have you felt the need to **Cut down** on your drinking? [ ] Yes [ ] No

Do you feel **Annoyed** by people complaining about your drinking? [ ] Yes [ ] No

Do you feel **Guilty** about your drinking? [ ] Yes [ ] No

Do you ever drink an **Eye-opener** in the morning to relieve shakes? [ ] Yes [ ] No

_______________________________________ _______________________

Patient Signature Date

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Dear Patient,

It is the mission of our practice to have a strong and supportive relationship with our patients. The following information should be useful to you.

If you have any questions, please feel free to contact our office at (201) 634-1811. Our staff will be happy to assist you.

OFFICE HOURS: EMERSON, CLIFTON, SOMERSET

- Monday – Thursday 9:00am – 5:00pm
- Friday 9:00am – 3:00pm

APPOINTMENTS

- If you need to cancel your appointment, please notify our office as soon as possible.

PRESCRIPTIONS

- Medication prescriptions are given and refilled during your office visit. Please be aware of your medication needs and address this with your Physician during your office visit.

XRAY'S, MRI'S & CT SCANS

- Please be sure to bring the actual films with you to EACH appointment. The films should be kept dry and out of the sun.

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