Patient Registration Form
Dr. Eckstein, Dr. Nylund, Dr. Pruthi, Dr. Seigal
450 Seventh Avenue at 34th Street - Suite 1004
New York, NY 10123

Date:_____

PATIENT INFORMATION:
Last Name:_____ First Name:_____
Date of Birth: _____ Age:_____ Social Security No.:_____Sex: F___ M ___
Married:____ Single: ____ Divorced: ____ Widowed:____
Home Address:_____Apt. #____
City:_____ State:_____ Zip Code: _____
Home Phone No.: _____ Emergency Phone No.: _____
Work Phone No.: _____ May we contact you at work? Yes ____ No ____
Referring Doctor: _____ Phone No.: _____

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PRIMARY INSURANCE:
Name of Insurance Plan: _____ Insurance ID No.: _____
Name of Employer: _____ Address: _____
Relationship to Patient: Self: _____ Spouse: _____Child: ____ Other: _____
Employer of Insured: _____ Phone No.: _____

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GUARANTOR INFORMATION:
Check here if same as Patient Information: _____
Last Name: _____ First Name: _____
Date of Birth: _____ Social Security No.: _____ Sex: F ___ M ___
Home Address: _____ Apt. # ___
City: _____ State: _____ Zip Code: _____
Home Phone No.: _____ Emergency Phone No.: _____
Work Phone No.: _____ May we contact you at work? Yes ____ No ____

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SECONDARY INSURANCE:
Check here if no Secondary Insurance: _____
Name of Insurance Plan: _____ Insurance ID No.: _____
Name of Employer: _____ Address: _____
Relationship to Patient: Self: _____ Spouse: _____Child: ____ Other: _____
Employer of Insured: _____ Phone No.: _____

I hereby authorize and direct my physician, having treated me, to release to government agencies, insurance carriers or others who are financially liable for my hospitalization or medical care, all information needed to substantiate payment for such hospitalization and medical care, and to permit representatives to examine and make copies of all records related to such treatment.

Patient Signature: _____ Date: _____

Patient Name _____ Patient ID No._____

Why are you here today? _____

_____

_____

What medications are you currently taking? _____

_____

List any allergies you may have _____

_____

Do you have pain in any of these areas: □ Back □ Neck □ Shoulders □ Knee □ Hip □ Elbow □ Wrist

ILLNESSES

MAJOR DISEASE:
□ Diabetes
□ Hypertension
□ Angina
□ Heart Disease
□ Heart Attack
□ Arrhythmia
□ Murmur
□ Mitral Valve Prolapse
□ Stroke
□ Chest Pain

HEENT:
□ Headaches
□ Eye Problems
□ Hearing Problems

RESPIRATORY:
□ Asthma
□ Bronchitis
□ Frequent Colds
□ Lung Disease
□ Shortness of Breath
□ Tuberculosis
□ Emphysema

ARTHRITIS:
□ Osteoarthritis
□ Rheumatoid
□ Gout
□Sero-negative: Reiter's, PsA, Anklyosing Spondylitis, CCPD, IBS

VASCULAR:
□ Anemia
□ Sickle Cell
□ Bleeding Disorders
□ Poor Circulation
□ Night Cramps
□ Leg Pain When Walking
□ Vein Problems
□ Spider Veins
□ Varicose Veins
□ Swelling Phlebitis
□ Leg Ulcerations
□ Blood Clots
□ Transfusions

GASTROINTESTINAL:
□ Ulcers
□ Stomach Problems
□Hiatal Hernia
□Bowel Disorders
□ GI or Rectal Bleeding
□ Acid Reflux (GERD)

MISCELLANEOUS:
□ Epilepsy
□ Thyroid Disease
□ Muscle Disease
□ Kidney Problems
□ Bladder Problems
□ Prostrate Problems
□ Venereal Disease
□ Skin Conditions
□ Cancer History
□ Hepatitis

PSYCHOLOGICAL:
□ Anxiety
□ Depression
□ Psychiatric Conditions
□ Drug Dependence
□ Alcohol Dependence

OTHER ILLNESSES:
_____
_____

SOCIAL HISTORY:
Occupation: _____

□ Single
□ Married

Alcohol _____ oz/day/week

Athletic Activities: _____

Tobacco: _____ packs a day for ___ years

FAMILY HISTORY: _____

I hereby give my permission to Dr. _____ to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition. I also hereby assign to the above named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.

Signature of Responsible Party _____ Date _____

AUTHORIZATION FOR USE OF SIGNATURE ON FILE
FOR CLAIM AUTHORIZATION

Enrollee Name:_____

Enrollee Social Security No.:_____

I, _____, authorize _____
Enrollee Name Provider Name

to mark the section "ENROLLEE'S OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE".

This section authorizes:

1. The release of any medical information necessary to process this claim, and

2. Payment of medical benefits to the undersigned physician or supplier of services described below.

This authorization will remain in full force until terminated in writing by the Enrollee.

_____ _____
Enrollee Signature Date

CONFIDENTIALITY POLICY
Effective April 14, 2003

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

Drs. Eckstein, Ianniello, Nylund, Pruthi and Seigal located at Seventh Avenue at 450 Seventh Avenue at 34th Street, Suite 1004, are committed to maintaining the confidentiality of its patients' protected health information (PHI). We emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform their job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard the confidentiality of PHI.

Consent obtained during the admission process to the Center covers use and disclosure of PHI for purposes of treatment, payment and health care operations, including quality assessment and measurement, and disease management activities. Before any PHI is disclosed for purposes of treatment, payment or healthcare operations, agreements with the recipients of such information are entered into to protect the confidentiality of PHI. If a patient is unable to give consent, family or legally appointed representatives will be authorized to release and/or receive access to information about the patient.

Business Associates: A Business Associate is an individual or entity under contract with us to perform or assist us in a function or activity which necessitates the use or disclosure of medical information for example: a medical record copy service, consultants, accountants, lawyers, medical transcription and third party billing companies. We require Business Associates to submit a written statement as to how they will protect the confidentiality and dispose of the PHI when use has been completed.

Federal law provides that we may use your PHI without further specific notice to you, or written authorization by you in the following categories:

For your treatment: In diagnosing and treating your injury or illness, we may disclose all or any portion of PHI to attending physicians, consulting physicians, nurses, technicians, medical students, interns, residency programs, continuing education training, to a home health agency or hospital to coordinate specific services, such as prescriptions, lab work, x-rays, and to other health care providers who have a legitimate need for such information in your care and continued treatment.

To obtain payment: We may use and disclose your medical information so that the services and treatment may be billed to, and payment may be collected from, your health insurer, HMO, or other company that arranges or pays the cost of your healthcare.

For health care operations: We may use and disclose your medical information for internal administration and planning that improve the quality and cost-effectiveness of the care that we deliver to you, for example: performance improvement, utilization review, internal auditing, accreditation, certification, licensing, educational and credentialing activities. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning your identity.

We may use or disclose medical information, without further notice to you, or specific authorization by you, where:

- Required by law
- Required for public health purposes;
- Required by law to report child abuse and neglect;
- Required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
- Required to report information about products under the jurisdiction of the Federal Drug Administration;
- Required by law for judicial or administrative proceeding;
- Required for law for enforcement purposes by a law enforcement official;

- Required by a coroner or medical examiner;
- Permitted by law to a funeral director;
- Permitted by law for organ donation purposes;
- Permitted by law to avert a serious threat to health or safety, for example, alert a person who may have been exposed to a communicable disease;
- Permitted by law to report information to your employer;
- Required by law to notify the appropriate government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence;
- Required to comply with laws in regard to workers' compensation;
- Permitted by law and required by military authorities if you are a member of the armed forces of the United States; and
- Required for research purposes (45 CFR #164.512(i)).

We may contact you by mail or phone, at your residence, to remind you of appointment or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phones at your residence.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Individual Patient Rights with Regard to Protected Health Information (PHI):

- Request restrictions on our use and disclosure described above - We are not required to agree with requested restriction. Request form for restriction is available from the Privacy Officer, Glenda Merced;
- To inspect and obtain copies of your medical information - Obtain a record request form from the Medical Records Department. Copies are provided within 30 business days of a request and with a reasonable fee charged. The fee is $0.75 per page copying charge, as well as any mailing costs if applicable, both of which must be paid by the patient before or at the time the copies are made;
- To request amendments of your medical information – Such requests must be in writing, and must state the reason for the requested amendment. We will notify you whether we agree or disagree with the requested amendment;
- To request an accounting of disclosures made by us, except for disclosures we make to you, or to carry out treatment, payment of health care operation, or as requested by your written authorization, or as permitted or required under 45 CFR #164.502, or for emergency notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law, or for research or public health purposes after being re-identified or limited to remove personally identifiable information, or disclosures made before April 14, 2003;
- To obtain this notice in a paper copy;
- To request in writing, alternative methods of confidential communications, i.e., you may request that we contact you at work or by mail;
- To report a violation of your privacy rights to the Privacy Officer as well as to file a written complaint with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services;
- To be informed of any changes to the Privacy Policy by posting a new notice in waiting areas around our premises. Patients have the right to request a copy of the new notice from the Privacy Officer.

CONFIDENTIALITY POLICY
450 Seventh Avenue – Suite 1004
New York, NY 10123

I have received a paper copy of the confidentiality policy, as required by HIPAA of 1996.

_____
Signature

_____
Print Name

_____
Date