Welcome to the New York Spine and Wellness Center!
Your first visit will be an initial evaluation to discuss treatment options specifically designed for you. You will not be receiving a procedure at this visit.

Please print the "New Patient Paperwork" from our Website.
Complete all the forms BEFORE you arrive for your appointment.

All patients must bring the 3 items listed below to your appointment:

1. The completed paperwork (7 pages total)
2. Your driver's license or other photo ID
3. Your current insurance card(s)

Please call 315-703-3488 with any questions, Monday through Friday 8:00 a.m. to 4:00 pm.

Thank you in advance for giving New York Spine and Wellness Center an opportunity to help you enjoy better health. We are committed to providing your pain management care.

New York
Spine & Wellness Center

Your Rights & Responsibilities

You as our patient have the right to:

1. receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin, or sponsor;
2. be treated with consideration, respect and dignity including privacy in treatment;
3. be informed of the services available from NYSW;(brochure)
4. be informed of the provisions for off-hour emergency coverage;
5. be informed of and receive an estimate of the charges for services, view a list of the health plans and the hospitals that the center participates with; eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
6. receive an itemized copy of your account statement, upon request when applicable;
7. Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;
8. receive information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both. An informed consent shall include, as a minimum, the provisions of information concerning the specific procedure or treatment, or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting knowledgeable decision;
9. refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of such action;
10. refuse to participate in experimental research;
11. voice grievances and recommend changes in policies and services to the staff, the Governing board and the NYS Department of Health without fear of reprisal;
12. Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health
13. privacy and confidentiality of all information and records pertaining to the patient's treatment;
14. approve or refuse the release or disclosure of the contents of your medical records to any health care practitioner and/or health care facility, except as required by law or third-party payment contract;
15. access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access;
16. be informed of the credentials of your Healthcare Professionals
17. change their provider if other qualified providers are available;
18. make known your wishes in regards to your Health Care Proxy

You have the responsibility to;

19. provide complete and accurate information regarding your health status, medical history, prescription medicine , over the counter medicine and supplements being taken;
20. notify your physician and NYSW Staff of any changes in your health condition;
21. follow the advice and instructions given to you by NYSW Staff;
22. ask questions of the NYSW Staff to fully understand care given to you;
23. adhere to NYSW payment policy ;
24. to provide a responsible adult to transport him/her from the center and remain with him/her for 24 hours, if required by his/her provider;
25. keep appointments and to notify NYSW Staff of any inability to do so;
26. cooperate with NYSW Staff and visitors of all races, color, sex, religion, age, nationalities, marital status, sexual orientation, and ethnic origin.

Today's Date ____/____/____

Please complete and give to receptionist with your insurance cards.

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐Mr ☐Mrs ☐Miss ☐Ms	Age	Birth Date / /	Sex M / F	Employer Name	Occupation

Street Address	City	State	Zip	Social Security #	Home Phone # ( )	Cell Phone # ( )

Referring Physician	Referring Physician Phone # ( )	Primary Care Physician	Primary Care Physician Phone # ( )

Pharmacy Name	Pharmacy Phone # ( )	Employer Phone # ( )

Emergency Contact Name	Relationship	Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )

Power of Attorney Name if Applicable	Phone # ( )	Legal Document for P.O.A. Received Date / /

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD(S) TO THE RECEPTIONIST)

Primary Insurance	ID # (include prefix or suffix)	Group #	Plan #

Insurance Carrier Address	Relationship to Subscriber(ie. spouse, parent)

Name of Subscriber	Subscriber Date of Birth	Subscriber Social Security #	Subscriber's Employer

Secondary Insurance	ID # (include prefix or suffix)	Group #	Plan #

Insurance Carrier Address	Relationship to Subscriber(ie. spouse, parent)

Name of Subscriber	Subscriber Date of Birth	Subscriber Social Security #	Subscriber's Employer

WORKERS COMPENSATION INFORMATION if you have more than one active workers compensation claim please complete the information for each separately below

Date of Injury	Injury (body area covered)	Insurance Carrier Name	Employer

WCB #	Carrier Case #	Case Worker Name and Phone Number

Ins. Carrier Address	City	State	Zip	Apportionment %

Second Date of Injury	Injury (body area covered)	Insurance Carrier Name	Employer

WCB #	Carrier Case #	Case Worker Name and Phone Number

Ins. Carrier Address	City	State	Zip	Apportionment %

NO FAULT INFORMATION

Date of MVA	Insurance Carrier Name	No Fault Claim #

Ins. Carrier Address	City	State	Zip

Adjuster Name and Number

I authorize release of all medical information necessary to process my medical claims. I also authorize my insurance company to make payment directly to the NY Spine & Wellness Center for services rendered to the above named patient. I understand that I am fully responsible for all charges incurred for treatment rendered to the above named patient. Failure to give 24 hour notice of cancellation of a NCS/EMG study or a procedure or no-showing for a NCS/EMG study or a procedure will result in a charge of $50.00 per occurrence. This charge cannot be billed to the insurance company. It will be my responsibility.

____

Patient/Relative/Guardian* Print Name Date/Time

____

Relationship to Patient

____

Interpreter (if required) Print Name Date/Time

____

Witness Print Name Date/Time

*The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

New York
Spine & Wellness Center

Initial Visit Questionnaire
All questions should be answered by patient.

Pt. Name: ______________________ Age: ______ DOB__________ Referring MD: ______________________ Date: __________

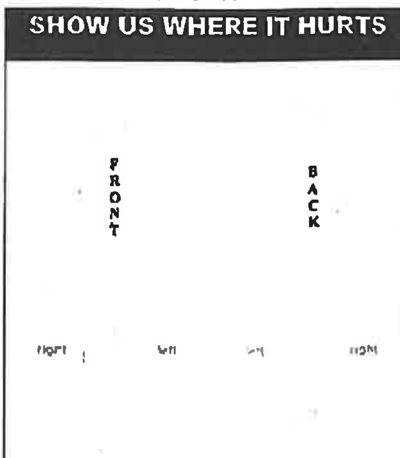
The diagnosis of Chronic Pain has been added to the approved diagnoses for treatment with Medical Cannabis. Is this a treatment option that you would be interested in? Y☐ N☐

1. Do you have any of the following Health Directives? ☐ Health-Care Proxy ☐ Durable Power of Attorney Health ☐ Legal Guardian
2. How long have you had this pain? ________ Can onset of pain be traced to a specific event/injury? Please Specify: ____________________
3. How would you describe your pain?
   Burning☐ Stabbing☐ Dull☐ Sharp☐ Aching☐ Numbness☐ Pins and Needles☐ Other: ____________________
4. My pain is constant☐ My pain will come and go☐

   Place an X on the scale that best indicates the severity of your pain.
   Today: No Pain -- Worst Possible Pain
   Good Day: No Pain -- Worst Possible Pain
   Bad Day": No Pain -- Worst Possible Pain

   What helps decrease your pain (position, exercise, medications, etc.)?
   ____

   Does anything (position, exercise, medications, etc.) worsen your pain?
   ____



5. Are there any rashes or blisters over the painful area? ____________
6. Does your pain keep you awake? ________
7. Check all you have tried and indicate if it was helpful or not.

☐Physical Therapy	Did it help? Y N	☐Hypnosis	Did it help? Y N
☐Surgery	Did it help? Y N	☐Acupuncture	Did it help? Y N
☐Biofeedback	Did it help? Y N	☐Chiropractor	Did it help? Y N
☐TENS Unit	Did it help? Y N	☐Massage Therapy	Did it help? Y N
☐Nerve Blocks	Did it help? Y N	☐Behavioral Health	Did it help? Y N

Yes No

8. Have you ever seen a Hematologist (blood doctor) for blood issues such as clotting or bleeding? Yes☐ No☐
   If yes, explain ____________________
   Yes No
9. List all medications and dosage: (include over the counter pain relievers/vitamins/supplements)
   ________ ________ ________ ________
   ________ ________ ________ ________
10. Are you on any blood thinners (i.e. Coumadin, Plavix etc.)? Yes☐ No☐ If yes, what? ____________
11. Do you take aspirin, Aleve, naproxen or any products containing aspirin? Yes☐ No☐ How much? ____________
12. Do you have any medication allergies? Yes ☐ No☐ Please list medication names and reactions::
    ________ ________ ________ ________
    ________ ________ ________ ________
13. Are you allergic to any of the following? **Latex** Yes☐ No☐ Adhesive Tape Yes☐ No☐ **IVP Dye** Yes☐ No☐
14. **Do you have or ever had any of the following diseases or conditions?**

Y N Heart Attack/Stroke	Y N Heart Surgery	Y N Heart Murmur	Y N Pacemaker/ICD
Y N Alcohol/Drug Abuse	Y N Diabetes (mellitus)	Y N Artificial Valves	Y N GERD
Y N HIV+/Aids	Y N Diabetes (insipidus)	Y N Hepatitis	Y N Thyroid Conditions
Y N Frequent Neck Pain	Y N Shingles aka (herpes zoster)	Y N Cancer aka (malignant neoplasm)	Y N Liver Conditions
Y N High/Low Blood Pressure	Y N Emphysema	Y N Anemia	Y N Kidney Conditions
Y N Severe/Frequent Headaches	Y N Glaucoma	Y N Arthritis	Y N Chemotherapy
Y N Fainting/Seizures/Epilepsy	Y N Psychiatric Problems	Y N Ulcers	Y N MRSA
Y N Asthma	Y N Kidney Problems	Y N Artificial Bones/Joints	Y N Tuberculosis
Y N Alzheimer/Dementia			

Any other diseases or conditions: ______________________________

15. Is there a chance that you are pregnant? Yes☐ No☐

16. Please list any surgery's and approximate dates:

__________ __________ __________ __________
__________ __________ __________ __________
__________ __________ __________ __________

17. Is there a history in your family of?
High Blood Pressure☐ Heart Disease☐ Diabetes☐ Arthritis☐ Cancer (malignant neoplasm) ☐ Type of Cancer: __________

18. Do you use alcohol or tobacco regularly: Yes☐ No☐ Specify Quantity: __________

19. Is there a history or current use of illegal substances? (Marijuana, Cocaine, narcotics, amphetamines, etc.) Yes☐ No☐
If yes what? __________

20. Do you use Medical Cannabis? Yes☐ No☐

21. Have you seen a psychiatrist for your pain? Yes☐ No☐ Have you attempted suicide because of your pain? Yes☐ No☐

22. Are you unable to work because of your pain? Yes☐ No☐

23. Are you currently, or have you previously, been involved in lawsuit regarding your pain? Yes ☐ No ☐

24. Review of Systems: Please indicate any of the following symptoms you are currently experiencing:

Constitution:	Fever:	No	Yes	Comment:	
	Weight loss:	No	Yes	Comment:	
Eyes:	Vision Problems:	No	Yes	Comment:	
Ears/Nose/Throat/Mouth:	Problems:	No	Yes	Comment:	
Cardiovascular:	Chest Pain:	No	Yes	Comment:	
	Shortness of Breath	No	Yes	Comment:	
	Palpitations:	No	Yes	Comment:	
	Foot Swelling:	No	Yes	Comment:	
Respiratory:	Cough/Wheeze:	No	Yes	Comment:	
Gastrointestinal:	Constipation:	No	Yes	Comment:	
	Diarrhea:	No	Yes	Comment:	
	Abdominal Pain:	No	Yes	Comment:	
	Nausea:	No	Yes	Comment:	
Genitourinary:	Problems:	No	Yes	Comment:	
Musculoskeletal:	Problems:	No	Yes	Comment:	
Skin:	Changes/Problems:	No	Yes	Comment:	
Neurological:	Fainting:	No	Yes	Comment:	
	Dizziness:	No	Yes	Comment:	
Psychiatric:	Depression:	No	Yes	Comment:	
Hormonal	Problems:	No	Yes	Comment:	
Hematology/Lymphatic:	Problems:	No	Yes	Comment:	
Endocrine:	Diabetes:	No	Yes	Comment:	
	Thyroid:	No	Yes	Comment:	

By signing below, I certify that the answers are true and complete to the best of my knowledge.

Patient/Relative/Guardian Signature* __________ Print Name __________ Date __________

Relationship to Patient __________

Interpreter (if required) __________ Print Name __________ Date __________

Witness __________ Print Name __________ Date __________

**The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity, please obtain proof of guardianship/POA*

db 12/19/16 rev. 02/06/17 rev. db04/13/17 rev.04/18/17, rev. 04/24/17 rev. 05/01/2017 rev. 10/03/2017 rev. 12-12-17

Today's Date______________________

Name____________________________________ DOB_________________

Dear Patient, we are requiring all of our patients to complete this questionnaire in the event you are on or going to be considered for opioid therapy.

		Mark Each box that applies
1. Family History of Substance abuse	Alcohol	☐
	Illegal drugs	☐
	Prescription Drugs	☐
2. Personal History of Substance abuse	Alcohol	☐
	Illegal drugs	☐
	Prescription Drugs	☐
3. Age(mark Box if 16-45)		☐
4. History of preadolescence Sexual Abuse		☐
5. Psychological Disease	Attention deficit / Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia	☐
	Depression	☐

I, the patient named above , have reviewed and completed the above form.

Initial___________________

Name ______________________ DOB ______________ Date ____________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ____ + ____ + ____

=Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

(revised 6/18/2019)

Patient Payment Policy

Thank you for choosing the New York Spine and Wellness Center. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. Please sign below that you have read and agree to this Policy.

- We accept cash, check, Visa, MasterCard, Discover and American Express.
- All fees are based on the type of service provided for your care and related services. Our fees are competitive for this region.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined in this document.
- All co-pays are expected to be paid at check in the day of your visit. We do not waive co-pays.
- In the event you have a past due balance, we will work with you to remedy the situation; you may experience an interruption in your care until the matter is settled.
- If your account is more than 180 days overdue, it will be referred to a collection agency. This is a last resort and done reluctantly after we have exhausted efforts for voluntary payment. You will be responsible for all reasonable collection costs incurred by our practice.
- If you have, or will be receiving a workers comp settlement, or a "Section 32", related to the same injuries we treat you for, you will be held solely responsible for the bills, **not your private insurance company**. You will be expected to pay at the time of visit.
- **We do not participate with No-Fault.** As a courtesy to you we will bill your NF carrier if you agree to sign the Authorization to Pay Form. In the event your carrier payment is delayed or denied for any reason **YOU will be held solely responsible for all bills**.
- **Claims denied due to non-compliance with your NF carrier, will not be billed to your private insurance. This includes, but is not limited to Medicaid or a Managed Medicaid Product.** You immediately become responsible for all outstanding charges.
- In the event that a service provided to you, is denied by your insurance carrier for any of the following reasons, but not limited to: non-covered service, experimental, investigational or not medically necessary, you will be responsible for the payment of the service. **Please verify coverage of services with your insurance carrier.**
- An estimated amount for the service is available upon request.
- Do not make any notations or changes to this document, if you do we will not be able to treat you.

Acknowledgement and Authorization

I have read, understand, and agree to the above Payment Policy. I understand that charges not covered by my insurance company, **as well as co-payments and deductibles, are my responsibility.**

I authorize my insurance benefits to be paid directly to New York Spine and Wellness Center.

I authorize New York Spine and Wellness Center to release any medical or other information to my insurance company when requested.

____

(**PRINT** name of patient)

______________________________ ______________________

(**SIGNATURE** of patient) Date of Signature

Attention Medical Records
5496 East Taft Road, North Syracuse, NY 13212

PERMISSION FOR VERBAL COMMUNICATION

Patient Information (Please Print)

Name: Last First Middle **Date of Birth**

Address: Street Address City State Zip Code

I permit New York Spine and Wellness Center, their physicians, nurses and other personnel to discuss my health information, in person or by telephone, with the following family members or friends; (List family members /friends and state the relationship to the patient).

Medical Information

Name	Phone Number	Relationship
1.		
2.		
3.		

Behavioral Health Information

Name	Phone Number	Relationship
1.		
2.		
3.		

Release of information under this document is limited to verbal discussions. This document does not permit release of any written health information.

This authorization is limited to the following time frame from __________(date) to _________(date). If no dates are indicated, this form will remain in effect for an unlimited amount of time or until it is revoked in writing.

If, at any time I do not want verbal discussions to be permitted between NYSWC and any individuals named above, I must notify NYSWC by contacting my provider.

Signature of Individual Date

If this Authorization is to be signed by a Personal Representative of the Individual, please complete the following:

Signature of Personal Representative Printed Name of Personal Representative Date

Description of authority: ______________________________

(A personal representative must provide legal proof of representation, e.g., guardian, health care proxy, Power of attorney)

Form 14P