New York
Spine & Wellness Center

Welcome to 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 receive a procedure/injection at this visit.

Please print and complete all forms in this packet BEFORE you arrive for your appointment.

All Patients must bring the following **4** items to your appointment:

1. THE COMPLETED NEW PATIENT PAPERWORK
2. YOUR DRIVERS LICENSE OR PHOTO ID
3. YOUR CURRENT INSURANCE CARD(S)
4. COVID-19 VACCINATION CARD
   (IF you have been vaccinated)

For questions about your first visit, please call our New Patient coordinator
Monday through Friday
8:00 A.M. — 4:00 P.M.
315-552-6700, OPTION 2

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

We look forward to meeting you!

New York Spine & Wellness Center

Today's Date ____ /____ /____

Please complete and give to receptionist with your insurance cards.

PATIENT INFORMATION

Patient Name: Last First Middle	Birth Date / /	Sex M/ F/ NB	Employer Name	Occupation
Street Address City State Zip		Social Security #		Preferred Phone # ( )
Emergency Contact	Contact's Preferred Phone# ( )	Relationship	Patient's Email Address	
Referring Physician	Primary Care Physician	Pharmacy Name	Pharmacy Phone # ( )	

PRIMARY INSURANCE INFORMATION

PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST

Insurance Carrier	Name of Subscriber	ID # (include prefix or suffix)	Relationship to Subscriber (e.g. spouse)
Subscriber Date of Birth / /	Subscriber Social Security #	Subscriber's Employer	Insurance Carrier Address

SECONDARY INSURANCE INFORMATION

PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST

Insurance Carrier	Name of Subscriber	ID # (include prefix or suffix)	Relationship to Subscriber (e.g. spouse)
Subscriber Date of Birth / /	Subscriber Social Security #	Subscriber's Employer	Insurance Carrier Address

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 #
Adjuster Name and Number		
Ins. Carrier Address City State Zip		

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 an NCS/EMG study or a procedure or no-showing for an 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.

It is your right to refuse to answer the following census.Please complete this brief survey in order to assist in healthcare studies. Thank you.

Ethnicity:	Race:	Language:
☐ Hispanic/Latino	☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian	☐ English ☐ French
☐ Not Hispanic/Latino	☐ Black/African American ☐ White ☐ Unknown	☐ Spanish ☐ Creole
☐ Refuse to report	☐ More Than 1 Race	☐ Other

New York Spine & Wellness Center

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

PERMISSION FOR 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, or via electronic communication 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, and electronic communication. This document does not permit release of records.

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 communication of any form 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)

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. **We will do our best to be knowledgeable about all of the many different insurance plans, however, it is the patient's responsibility to know their insurance and what may or may not be covered.** Please sign below that you have read and agree to this Policy.

- All co-pays to are to be paid at check-in, the day of your visit. **We do not waive co-pays**. We accept cash, check, Visa, MasterCard, Discover and American Express.
- All fees are based on the type of service provided for your care & related services. The 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.
- 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 the day of your visit.
- **We do not participate with No-Fault.** As a courtesy, 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 by your NF carrier due to your 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.
- If 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 cost 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 all of the above. 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.

Signature of Patient/Relative/Guardian*	Patient DOB	Print Name of Patient
Relationship to Patient		Print name of Relative/Guardian*
Interpreter (if required)		Today's Date

* 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

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.

New York
Spine & Wellness Center

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 with a Yes or No	YES	NO
Family history of substance abuse		
Alcohol		
Illegal drugs		
Rx drugs		
Personal history of substance abuse		
Alcohol		
Illegal drugs		
Rx drugs		
Age between 16-45 years		
Psychological disease		
ADD, OCD, bipolar, schizophrenia		
Depression		

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

Initial_____

New York Spine & Wellness Center

Initial Visit Questionnaire
All questions should be answered by patient.

Pt. Name: _____ Age: _____ DOB_____ Todays Date: _____

If you have a diagnosis of Alzheimer's or Dementia the following are required:

- You must always be accompanied by your Personal Representative, named on the Health Care Directive, at every office or procedure appointment.
- Health Care Directive document must be presented to New York Spine and Wellness Center at patients' initial visit.
- If you present with a diagnosis of Alzheimer's or Dementia without your Personal Representative and without the Health Care Directive document you will need to be rescheduled.

Have you ever been a patient at our practice under another name or gender? Y ☐ N ☐

(If yes, clearly print name and gender) _____

Birth Sex: M / F

Preferred pronouns:

_____

_____

_____

I identify as:

☐Male
☐Female
☐Female-to Male/Transgender Male
☐Male-to Female/Transgender Female
☐Genderqueer
☐Other
☐Decline
☐Intersex

Do you have any of the following Health Directives? ☐ Health-Care Proxy ☐ Durable Power of Attorney Medical or Dual ☐ Legal Guardian

How long have you had this pain? _____ Can onset of pain be traced to a specific event/injury such as car accident or work accident?

Please Specify: _____

_____

Describe your pain? Check all that apply: Numbness☐ Pins and needles☐ Burning☐ Aching☐ Stabbing☐ Sharp☐ Dull☐

Constant☐ Comes and goes away☐ Other: _____

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 pain can I live with: No Pain ---------- Worst Possible Pain

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

_____

_____

_____

What are you unable to do now because of your pain that you were able to do before? Does anything worsen your pain (position, exercise, medications, etc.)

_____

_____

_____

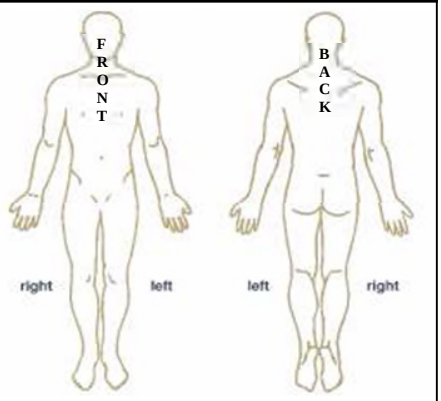
_____

Any rashes/blisters over painful area? Y N Does your pain keep you awake at night? Y N

Check all you have tried and indicate if it was helpful or not.

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

SHOW US WHERE IT HURTS



Please mark the painful body areas on the drawing above.

Do you use any assisted devices? Y N Check all that apply:

☐ Cane ☐ Wheelchair ☐ Brace ☐ Crutch ☐ Prosthetic Device ☐ Other _____

Have you participated in Physical Therapy (PT)? Y N At what PT office did you do your physical therapy? _____

Please list start and end dates you completed your PT: _____

☐Completed greater than 4 weeks of PT. ☐ Completed less than 4 weeks of PT.

List all medications and dosage: (include over the counter pain relievers/vitamins/supplements)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you taking a blood thinner medication (i.e. Coumadin, Plavix etc.)? Y N Do you take aspirin/aspirin containing products? Y N

Are you taking a biologic medication (i.e. Humira, Enbrel etc.)? Y N Do you use Medical Cannabis? Y N

Have you ever seen a Hematologist (blood doctor) for blood issues such as clotting or bleeding? Yes☐ No☐

If yes, explain_____

Quite often our office will need to contact one or more of your specialty physician's for copies of medical records, diagnostic test results, medication and/or surgical clearances. Please provide the names and office contact number for any of the following specialty physicians that you see.

	Physician Name	Telephone Number
Referring Physician	_____	_____
Primary Care Physician	_____	_____
Gastrologist	_____	_____
Hematologist	_____	_____
Cardiologist	_____	_____
Rheumatologist	_____	_____
Oncologist	_____	_____
Dermatologist	_____	_____
Neurologist	_____	_____
Other	_____	_____

Do you have any <u>medication</u> allergies? Yes ☐ No☐ <u>Please list medication names and reactions from those medications</u>:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to:

<u>Latex</u> Yes☐ No☐ Reaction _____ <u>Adhesive Tape</u> Yes☐ No☐ Reaction _____ <u>IVP Dye</u> Yes☐ No☐ Reaction _____

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:

_____

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

Please list any surgeries and approximate dates:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Do you have any of the following implanted items or devices?

☐ Pacemaker ☐ ICD ☐ Spinal Cord Stimulator ☐Heart/Cardiac Stents ☐ Glucose Monitor ☐ Sleep Apnea Monitor

Is there a history in your family of any of the following?

High Blood Pressure Y N What is the family relation: _____
Heart Disease Y N What is the family relation: _____
Diabetes Y N What is the family relation: _____
Arthritis Y N What is the family relation: _____
Cancer (malignant neoplasm) Y N Type of Cancer: _____ What is the family relation: _____

Do you use alcohol regularly: Yes☐ No☐ Specify quantity and how often: _____
Do you use tobacco regularly: Yes☐ No☐ Specify quantity and how often: _____

Is there a history or current use of illegal substances? (Cocaine, narcotics, amphetamines, etc.) Yes☐ No☐
If yes what? _____ How often/when? _____
Do you use recreational Marijuana? Yes☐ No☐ How often/when? _____

Are you currently working? Yes ☐ NO ☐ Retired ☐ Current or Previous Occupation _____
Are you unable to work because of your pain? Yes☐ No☐
Do you currently hold an active CDL (Commercial Driver's License)? Yes ☐ NO ☐
Are you currently, or have you previously, been involved in lawsuit regarding your pain? Yes☐ No☐
Have you seen a psychiatrist for your pain? Yes☐ No☐
Have you attempted suicide? Yes☐ No☐

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 Signature (if required) Print Name Date

_____ _____ _____
Witness Signature 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*

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