New York Spine & Wellness Center

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

Name: _____ DOB: _____

It is your right to refuse to answer the following census. Please complete this brief survey and return with the new patient packet, in order to assist in healthcare studies. Thank you.

Race:
- ☐ **Asian**
- ☐ **Native Hawaiian**
- ☐ **Black/African American**
- ☐ **American Indian/Alaska Native**
- ☐ **White**
- ☐ **More Than 1 race**
- ☐ **Unknown**

Ethnicity:
- ☐ **Hispanic/Latino**
- ☐ **Not Hispanic/Latino**
- ☐ **Refuse to report**

Language:
- ☐ **English**
- ☐ **Spanish**
- ☐ **French**
- ☐ **Creole**
- ☐ **Other**

Please provide us with your email address:

Help us improve the care we deliver by providing your email address for a survey about your visit. Our survey partner, Survey Vitals, will hold your information in strict confidence. Patients will be chosen on a random basis for this survey, and it will only be used to help us improve our quality of care.

- Your information will never be sold to a third party.
- Your email will not be used for promotional marketing.
- Information is confidential, in compliance with HIPAA patient privacy regulations.

Provider Seeing Today: _____
Patient Name: _____
Date of Birth: _____ (mm/dd/yyyy)
Email Address: _____
Check here if you do not have email ☐
From everyone at N.Y. Spine and Wellness Center, thank you for trusting us with your care

New York Spine & Wellness Center

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)

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

AANEM Accredited Laboratory *Exemplary Status

EMG / NERVE CONDUCTION STUDIES PATIENT FORM

Patient: _____

Age: _____ Height: _____

Today's Date: _____

Handedness: _____ Right Handed _____ Left Handed Other: _____

Who requested this test? _____
What is the problem for which you are being seen today? _____
_____

Any numbness? _____ YES _____ NO If yes, where are you numb?

_____

Any weakness? _____ YES _____ NO If yes, where are you weak?

_____

Any pain? _____ YES _____ NO If yes, where is your pain?

_____

Do the symptoms go down **one** of your arms or legs, **both** of your arms or legs, or not at all?

Do you have a pacemaker, defibrillator, or spinal cord stimulator? _____ YES _____NO

Are you diabetic? _____ YES _____ NO

Do you have more than 2 alcoholic drinks a day? _____ YES _____ NO

Does anyone in your family have diabetes or a neurologic disease? ____ YES _____NO

5496 East Taft Road / North Syracuse, New York 13212 - Telephone: 315-552-6700 / Fax: 315-552-6701
6711 Towpath Road / Suite 265, East Syracuse, New York 13057 - Telephone: 315-7033480 / Fax: 315-703-3481
5417 West Genesee Street, Suite 1 / Camillus, New York 13031 - Telephone: 315-432-4900 / Fax: 315-488-4190
nyspineandwellness.com