Multi-Specialty Pain Management, PC

3713 East Tremont Avenue Bronx, NY 10465
3058 East Tremont Avenue Bronx, NY 10461
76-65 Austin Street Forest Hills, NY 11375
Tel. (718) 792-4878 Fax (347) 851-6756

Demographics

Name:_____ **DOB:**___/___/_____
Address: _____
_____
SSN: _____ - ____ - _____ **Gender:** ☐ M ☐ F **Marital Status:** ☐ S ☐ M ☐ D ☐ W
Primary Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other ☐ Declined
Home #: _____ **Cell #:** _____ **Work #:** _____
Email: _____

Occupation:_____
Employer: _____ **Employer Address:**_____
Referring MD: _____ **Primary MD:** _____
Emergency Contact:_____ **Phone #:**_____
Relationship:_____

Pharmacy Name: _____ **Pharmacy Address:** _____
Pharmacy Phone: _____ **Pharmacy Fax:** _____
How did you hear about our office? _____

Private Insurance

Health Insurance: _____ **Effective Date:** ___/___/_____
Health Ins. Address: _____
Member ID #: _____ **Group #:** _____
Policyholder's Name: _____ **Referral required: Y N**
Policyholder's DOB: ___/___/_____ **SSN#:** _____ - ____ - _____ **Deductible $**_____
Co-Pay $_____ **Relation to Insured:** _____
Policyholder's Employer: _____

Health Insurance: _____ **Effective Date:** ___/___/_____
Health Ins. Address: _____
Member ID #: _____ **Group #:** _____
Policyholder's Name: _____ **Referral required: Y N**
Policyholder's DOB: ___/___/_____ **SSN#:** _____ - ____ - _____ **Deductible $**_____
Co-Pay $_____ **Relation to Insured:** _____
Policyholder's Employer: _____

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Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance

Patient: _____
Employer: _____
Claim/Group: _____
Social Security/ID number: _____

I hereby instruct and direct _____ Insurance Company to pay services rendered by the provider and have check made out and mailed to:

Multi Specialty Pain Management, PC
3713 East Tremont Avenue 2nd Floor
Bronx, New York 10465

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to *make out the check to me and mailed* it as follows, or bring in the check and sign it over to:

Multi Specialty Pain Management, PC
3713 East Tremont Avenue 2nd Floor
Bronx, New York 10465

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee. A photocopy of this assignment shall be considered as effective and valid as the original, adjuster, or attorney involved in this case.

Dated at Multi-Specialty Pain Management, PC on _____.
(date)

_____ Signature of Policyholder

_____ Signature of Witness

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Brian Haftel, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____,
(insert patient's name) Acknowledge receipt this day from MULTI-SPECIALTY PAIN MANAGEMENT, PC of a copy of the NOTICE OF PRIVACY PRACTICES of MULTI-SPECIALTY PAIN MANAGEMENT, PC.

DATE: _____ **_____**
(Patient's Signature)

Received By:

_____
(Print Name Of Staff Member)

_____
(Signature of Staff Member)

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Name: _____
Account: _____

Notification Policy:

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When returning calls and an answering machine picks up, we do not leave a message unless it is an appointment reminder. Information also will not be left with an authorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff of Multi Specialty Pain Management to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information chanes:

____ Yes ____ No **Home Telephone:**_____

____ Yes ____ No **Home Answering Machine**:_____

____ Yes ____ No **Home Fax:** _____

____ Yes ____ No **Work Telephone:**_____

____ Yes ____ No **Work Fax:**_____

____ Yes ____ No **Cell Phone and Voice Mail**:_____

____ Yes ____ No **Pager** :_____

Please list names of authorized people we may leave message with (i.e. spouse, boyfriend, girlfriend, parent, grandparent, etc).

_____ Yes ____ No ___
Name relationship

_____ Yes ____ No ___
Name relationship

_____ Yes ____ No ___
Name relationship

_____ Yes ____ No ___
Name relationship

Who may we discuss your financial situation with:

_____ Yes ____ No ___
Name relationship

_____ Yes ____ No ___
Name relationship

Signature: _____ **Date:** _____

MULTI-SPECIALTY PAIN MANAGEMENT
DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

_____
_____
_____

RE: Patient records and Doctor's lien

I do hereby authorize the above doctor's office to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness, which occurred/began on

_____

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may he necessary to protect said doctor adequately.
OUTSTANDING AMOUNT TO DATE: $_____

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.
I fully understand that I am responsible to notify the above doctor's office if I change attorneys or if my case is dropped. My attorney also is to notify the above doctor's office if the patient changes attorneys or if the patient's case is dropped.

DATED: _____ Patient's signature: _____

The undersigned, being attorney of record or authorized representative of insurance Carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

DATED: _____ **Attorney Signature: _____**

NOTICE: Please date, sign, and return one copy to doctor's office at once.