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?_____

Worker's Compensation Insurance

Date of Accident: ____/____/_____
Worker's Comp Carrier Name: _____
Worker's Comp Address: _____
Carrier Case#:_____ **WCB#:**_____

Adjuster/Case Mgr Name: _____
Phone #: _____ **Ext.**_____

Body part(s) injured established: _____

Attorney Name: _____
Address: _____
Phone #: _____ **Fax#:**_____

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PROVIDER: Brian Haftel MD,

NEW WORK WORKER'S COMPENSATION INSURANCE LAW
ASSIGNMENT OF INSURANCE BENEFITS

Patient Name: _____ Insurance Co.: _____

Date of Accident: _____ Insured Name: _____

In consideration of service render or to be rendered to the above named patient, I hereby authorize and assign payment directly to the above name provider of any and all first party Workers' Compensation benefits to which I may otherwise be entitled for services rendered by the provider, but not to exceed the provider's charges for such services as entitled by the schedule of the Workers' Compensation Board.

_____

IN CASE OF DENIAL FROM CARRIER

In consideration of care and services rendered or about to be rendered to myself during disability suffered as a result of an accident which occurred on or about _____, I hereby assign to the provider, a portion of the proceeds of any settlement or judgment to which I may become entitled from any party responsible for such accident as shall equal the full payment of said bill for such care and services, which bill is at present.

I hereby authorize and direct any party responsible for said accident and my attorney representing me in connection with any claim that I may have by reason thereof not to pay to me or anyone in my behalf any part of the portion of the proceeds hereby assigned but to retain in trust for said provider, the whole portion to pay the same without any further notice to me.

The terms of this assignment shall be part of any adjustment of any claim I may have by reason of said accident.

It is expressly understood that this assignment does not in any way relieve the patient from his obligation therefore.

WITNESS:

_____

_____
Patient's Signature or Guardian

_____
Date Signed

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.

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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:** _____