Multi-Specialty Pain Management, PC

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?
_____

Motor Vehicle No-Fault Insurance

Date of Accident: ____/____/_____

<u>Is your visit related to a slip and fall or lien case if yes skip down to attorney information</u>

Motor Vehicle Accident Name: _____
Motor Vehicle Accident Address: _____
Policy#:_____ **Claim#:**_____

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

Body part(s) injured established: _____

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

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to MULTII SECIALTY PAIN MANAGEMENT, PC, "(Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____,
not withstanding any other agreement to the contrary. (Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO,AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICTS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) **(Signature of Provider)**

MULTI-SPECIALTY PAIN MANAGEMENT,PC _____
(Date of signature)

3713 EAST TREMONT AVENUE_____

BRONX, NEW YORK 10465_____

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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)

Multi-Specialty Pain Management, PC

Tel. (718) 792-4878 Fax (347) 851-6756

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:** _____