

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? _____

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 be 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 changes:

___ 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).

_____ name _____ relationship Yes ___ No ___

_____ name _____ relationship Yes ___ No ___

_____ name _____ relationship Yes ___ No ___

_____ name _____ relationship Yes ___ No ___

Who may we discuss your financial situation with:

_____ name _____ relationship Yes ___ No ___

_____ name _____ relationship Yes ___ No ___

Signature: _____ **Date:** _____