Primary Language _____

Translator Needed _____

Today's Date _____ / _____ / _____ email address: _____

Reason for visit _____ Referred by ☐Dr._____ ☐Attorney_____
☐Family ☐Friend ☐Internet ☐Other

Who is your primary care physician? Name: _____Phone # _____

Was this injury related to an accident that occurred at work? YES ☐ NO ☐

Case manager YES ☐ NO ☐ Name _____ Phone # _____

Was this injury related to an accident which occurred in an Auto Accident? YES ☐ NO ☐

Adjuster YES NO Name_____ Phone# _____

PATIENT INFORMATION

First Name: _____MI_____ Last Name: _____

Address: _____Apt #_____City: _____State: _____Zip: _____

Home Phone :(_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ DOB: _____ / _____ / _____ Age: _____

SS#: _____ - _____ - _____ Sex: Male ☐ Female ☐ Marital Status: ☐ S ☐ M ☐ D ☐ W

Current Employer: _____ Phone #: (_____) _____

Emergency Contact: _____Relation: _____ Phone # (_____) _____

INSURANCE COVERAGE

Primary Insurance Company: _____ ID #: _____

Group#: _____ Policy Holder: _____ DOB _____ /_____/_____

Relationship to Patient: _____ Employer of Policy Holder_____

Secondary Insurance Company: _____ ID#_____

Group#: _____ Policy Holder: _____ DOB _____ / _____ /_____

Relationship to Patient: _____ Employer of Policy Holder: _____

AUTHORIZATION TO RELEASE INFORMATION and ASSIGNMENT OF BENEFITS

LIMITATION OF LIABILITY- I hereby certify that the above information is true and correct to the best of my knowledge. Certain insurance companies will only pay for services which they deem necessary. It is my understanding that it is the practice of this office to perform treatments which are deemed necessary and sufficient for the diagnosis of my condition. In the unlikely event that my insurance company fails to pay either myself or this office for any of these necessary services, I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per *HIPPA guidelines.* Furthermore, I agree to be financially responsible for any and all applicable deductibles and co-insurance payments.
RELEASE OF INFORMATION- I permit this office to disclose all or part of this patient's medical record to any person, corporation, or agency when required for the collection of benefits or upon my request by referring physician.
ASSIGNMENT OF BENEFITS- I hereby authorize this office to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to Dr. (or to the party who accepts assignment.) I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. I certify that the information I have reported with regard to my insurance coverage is correct. I confirm that I have read and fully understand the above.

Patient (or Guardian) Signature: _____ Date: _____

If Guardian, please PRINT your name _____

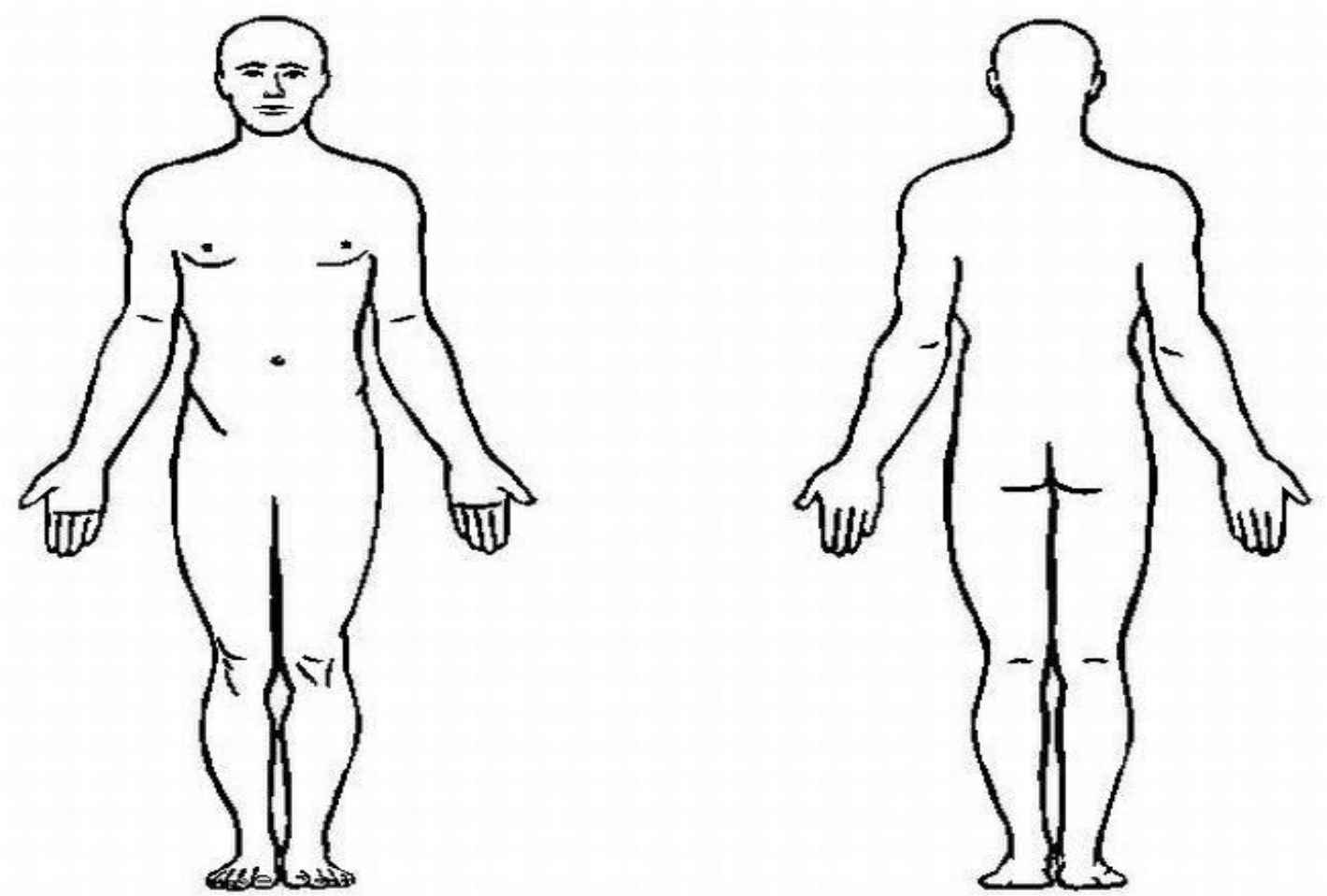
Name_____DOB: _____

Age:___Sex:____Weight:_____Height: _____

About your pain

On the drawings, please mark the areas of your body where you feel the pain.

Right *Left* *Left* *Right*



Please mark an "X" on your body where you feel the pain at its worst.

1. When did the pain start? _____

2. Did your pain develop: ☐ Suddenly or ☐ Gradually

3. Over time has your pain become: ☐ better or ☐ worse ☐ Remained unchanged

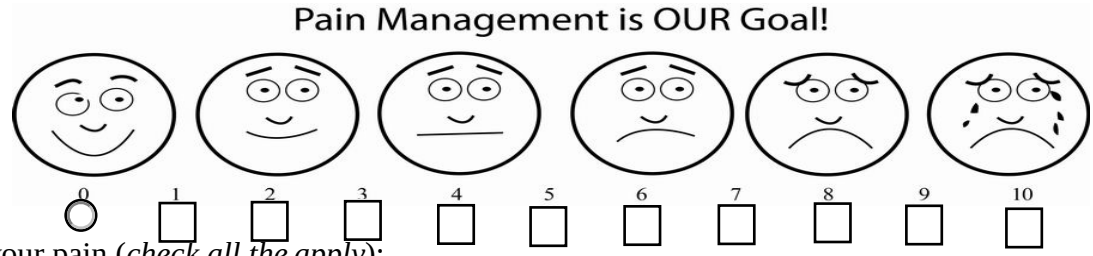
4. Were there any events that incited your pain?

☐ Lifting ☐ Twisting ☐ Bending ☐ Pulling ☐ Fall

☐ No apparent cause ☐ Work Injury ☐ Sport Injury

Other_____

5. Please mark below, how bad your pain is NOW?



6. Describe your pain (*check all the apply*):

☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Throbbing ☐ Cramping

☐ Stabbing ☐ Shooting ☐ Continuous ☐ Intermittent Other: _____

7. What makes the pain worse? (*check all the apply*):

☐ Standing ☐ Walking ☐ Sitting ☐ Driving ☐ Overhead activity

☐ Bending forward ☐ Bending backwards ☐ Twisting Other: _____

8. What makes the pain better? (*check all the apply*):

☐ Lying on ☐ Back ☐ Stomach ☐ Right side ☐ Left side

☐ Standing ☐ Walking ☐ Sitting ☐ Pain medication Other: _____

9. Does your pain awaken you from sleep? ☐ YES ☐ NO

10. Does the area of your pain ever change color? ☐ YES ☐ NO

11. Is there area of you pain sensitive to soft touch or clothing? ☐ YES ☐ NO

12. Have you ever been hospitalized for your pain problem? ☐ YES ☐ NO

13. Have you ever had surgery for this problem? ☐ YES ☐ NO

If yes, please describe_____

_____

14. Have you had any of these to help with your pain?

X – Ray	☐ YES	☐ NO	When_____
CT-scan	☐ YES	☐ NO	When_____
MRI	☐ YES	☐ NO	When_____
EMG	☐ YES	☐ NO	When_____
Myelogram	☐ YES	☐ NO	When_____
Discogram	☐ YES	☐ NO	When_____

15. What types of other doctors have you seen for this condition?

_____

16. What treatments were provided? Have you had Physical Therapy within the last year? If yes, what is the facility's name and phone number?

_____

_____

17. Do you currently have (*check all that apply*):

☐ Unintentional weight gain ☐ Unintentional weight loss ☐ Dizziness ☐ Double vision
☐ Chest pain ☐ Shortness of breath ☐ Drop attacks (passing out) ☐ Headaches
☐ Difficulty hearing ☐ Ringing of the ears ☐ Nausea/Vomiting ☐ Heartburn Palpitations
☐ Fever ☐ Chills ☐ Skin rashes ☐ Shingle ☐ Tremors
☐ Bowel or Bladder irregularities ☐ tingling in hands or feet ☐ Balance problems
☐ Difficulty walking ☐ Pain that wakes you ☐ pain that keeps you from falling asleep
☐ Morning stiffness ☐ Daytime fatigue ☐ Generalized weakness ☐ Depression
☐ Anxiety ☐ Bleeding disorder Other _____

18. Have you ever been diagnosed with (check all that apply):

☐ High blood pressure ☐ Diabetes ☐ Cancer ☐ Heart Disease
☐ Carotid artery disease ☐ High Cholesterol ☐ Kidney disease ☐ Lupus
☐ Stroke ☐ Asthma ☐ Sleep apnea ☐ Seizures ☐ Liver disease
☐ Ulcer ☐ Gout ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Lyme disease
☐ Carpal tunnel syndrome ☐ Multiple sclerosis ☐ Fibromyalgia ☐ Neuropathy
☐ Reflex sympathetic dystrophy ☐ Spinal stenosis ☐ Lumbar/Cervical disc disease
☐ Spinal fracture ☐ Ankylosing Spondylitis Other_____

19. Do you have a Pacemaker: ☐ Yes ☐ No

20. Please list any surgeries you have had (and the date performed):

1.	4.
2.	5.
3.	6.

21. What medical conditions run in your family?_____

_____

_____

22. Please list any allergies:

1.	
2.	
3.	
4.	
5.	

Please List any Medications.

	MEDICATION	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

23. About your social history. (Please mark all which apply):

☐ Single ☐ Divorced ☐ Widowed ☐ Married
☐ Student ☐ Employed ☐ Unemployed ☐ Retired ☐ Disability/Work Comp.

Occupation_____

24. Do you have any lawsuits pending regarding your pain? ☐ YES ☐ NO
Explain:_____

25. Do you exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never
What type of exercise you do? _____

26. Do you have a history of substance abuse? ☐ NO ☐ YES
If yes, what _____

27. Do you currently smoke? ☐ NO ☐ YES #packs per day_____

28. Do you drink alcohol? ☐ NO ☐ YES #drinks per day_____

PATIENT SIGNATURE_____DATE_____

REVIEWED BY_____MD DATE_____

Brooklyn PREMIER ORTHOPEDICS

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU REQUIRE MORE INFORMATION, PLEASE CONTACT OUR HIPAA COMPLIANCE OFFICER AT THE CONTACT INFORMATION AT THE END OF THIS NOTICE.

At BPO we understand that your medical information about you and your health is personal. Our practice is committed to protecting your medical information. We are required by federal and state laws to maintain the privacy of your Protected Health Information (PHI) and to give you this notice explaining our privacy practices with regard to that information. This notice explains your rights and our legal obligations regarding the privacy of your PHI.

Protected Health Information is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another health care provider, your health plan, your employer, or a healthcare clearing house that relates to (1) your past, present, or future physical conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information.

For your Treatment: Your PHI may be provided to a physician or healthcare provider (a specialist or laboratory) to whom you have been referred, to ensure they have the necessary information to diagnose, treat or provide you a service.

For Payment: Your PHI may be used and disclosed to enable us to bill and either collect payment from you, a health plan or a third party for the treatment and services you receive from us. As an example, we may need to give your health plan information of your treatment in order for your health plan to agree payment for that t r e a t m e n t .

For Health Care Operations: We may use and disclose your PHI in order to support the business activities of your physician's office. These activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians, medical students and other authorized personnel for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/ Health-Related and Services: We may use and disclose your PHI to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to y o u .

As required by Law: We will disclose your PHI about you when required to do so by international, federal, state, or local law.

Marketing & any purposes which require the sale of your information: These disclosures require your written authorization.

Any other uses and Disclosures not recorded in this Notice will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your PHI, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

The Right to Inspect and Copy: Under federal law you have the right to inspect and copy you PHI (we have up to 30 days to make your PHI available to you, fees may apply). You have a right to a Summary of your PHI instead of the entire record, or an explanation of the PHI which has been provided to you so long as you agree to this alternative form and agree to pay the associated fees.

The Right to an Electronic Copy of Electronic Medical Records: You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your medical records, if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fees may apply).

Brooklyn PREMIERORTHOPEDICS

Notice of Privacy Practices

The Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You may ask us not to use or disclose any part of your PHI and by law we must comply when the PHI pertains solely to a health care item or service which the health care provider involved has been paid out of pocket in full. You also have the right to request a limit on the PHI we disclose about you to someone involved in your care or payment of your care. Your request must be made in writing to our HIPAA Compliance Officer with specific instructions. If we agree to the restriction, we may only be in violation of that restriction for emergency treatment purposes. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

The Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured PHI.

The Right to Request Amendments: If you feel that the PHI we have is incorrect or in complete, you may ask us to amend the information. A request and the reason for the requested amendment must be made in writing to the HIPAA Compliance Officer at the information at the end of this Notice. In certain cases, we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy.

The Right to an Accounting of Disclosures: You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred six years prior to the date of request. Your request must be made in writing and you must indicate in what form you want the list, for example on paper or electronically. The first accounting of disclosures in any 12-month period will be free. Any additional requests within that same time period we may charge reasonable costs. You may withdraw or modify your request before the costs are incurred.

The Right to Request to Receive Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

Complaints:

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us you must make it in writing to our HIPAA Compliance Officer at the information at the end of this Notice. Complaints must be submitted within 180 days of when you knew of or suspected the violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W. Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hippa/, for more information. There will be no retaliation against you for filing a complaint.

If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the information at the end of this Notice. You have the right to request a paper copy of this Notice at any time even if you have agreed to receive this Notice electronically. A copy of this Notice may also be found on our website

Please sign below to acknowledge you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

Patient signature:……..Date:…….

Brooklyn Premier Orthopedics

We are committed to providing our patients with the best possible medical care. If you have special needs with regards to financial obligations, we are here to work with you. This financial policy has been established with these objectives in mind, and to avoid any misunderstandings or disagreements concerning payment for professional services.

1. Our office participates with various insurances plans. It is your responsibility to:
    - Bring an updated insurance card to every visit and inform us of any changes as they occur.
    - Be prepared to pay co-payment or deductible at every visit. Payment may be made by cash, check or credit card. For your convenience, you can request your co-payment to be billed to you for a $5.00 surcharge in addition to your co-payment.
    - For medical service not covered by your insurance, payment in full due at the time of visit.

2. Referrals: It is your responsibility to bring any required referrals for treatment, *at, or prior to the appointment.* If you do not have your referral, your visit may be rescheduled or you may be financially responsible.
3. If you have insurance that we do not participate in, *payment in full is expected at the time of service.*
4. If you are without insurance coverage, *your office visit requires an initial $250 payment*, payable in cash, check or credit card at the time of service. Follow up visit will be $150. We are unable to give you the total cost of the services prior to the treatment because we do not know the services the physician will deem necessary. Any remaining balance will be billed to the patient and/or the responsible party. We ask that you pay this as soon as you receive your statement, as there is a 50% interest charge per month overdue.
5. If the patient is a minor (18 years or younger), the parent or guardian of the minor is responsible for any payment due at time of service as well as the insurance information and referrals.
6. If you require any additional forms to be filled out by our physicians / staff that are not a part of standard office forms, our fee schedule is as follows:
    - Disability Forms: Short term: $25 Long term: $150
    - Other forms as needed range from $25 to $150
    - Patients will be charged a $25 no show fee if appointment is not canceled 24 hours in advance.

Our Practice believes that a good physician / patient relationships are based upon understanding and good communication. Please Notify the Front Desk Staff if you are having trouble making your payments.

X_____ _____

Signature of Patient or Responsible Party *Date*

1414 Newkirk Avenue
Brooklyn, NY 11226 Phone: (718) 759-6100 Fax: (718) 434-0070
142 Joralemon St 2nd floor
Brooklyn, NY 11210 Tel: (718) 759-6100 Fax: (718) 858-3700

FEE DISCLOSURE

Dr. _____ does not participate in the network of the patient's health care plan.

As an out of network physician, I have not agreed to any set rate that your health care plan may pay and I, may charge more.

You are required to understand what your health care plan covers if you obtain services from an out-of-network physician.

- **Your plan may not cover out of pocket network services at all, which may leave you to pay the full cost.**

- **If your plan covers out of network services your plan may require higher co-pays, deductibles and co-insurance for out of network care. You will have to pay these higher amounts plus any difference between your plan's allowed amount and what the out of network physician charges for the services.**

The patient acknowledges that the above physician is an out of network physician but has elected to obtain the services.

<u>Acknowledgment of Patient</u>

Signature _____ Date_____

If legal representative, indicate relationship to patient _____

Print Name of Patient _____

Print Name of Legal Representative _____

BROOKLYN PREMIER ORTHOPEDICS

WWW.BPORTHO.COM

Orthopedic Surgeons
Raz Winiarsky MD
Haydee Brown MD
Don Heitman MD

Spine Surgeons
Jonathan Lewin MD
Seth Grossman MD
Vagmin Vora MD

Isaac Abramchayev, RPA-C
Jennifer Conenna, RPA-C
Lauren Roop, PA-C
Kathy Migliore, PA-C

Pain Management Specialists
Steven Horowitz MD
Jonathan Simhaee MD
Marc Cohen MD
Jacob Peacock MD

Hand & Upper Extremity
Michael Horowitz MD

Podiatrist & Foot/Ankle Surgeon
Daniel Popowitz, DPM

DATE: _____

Prescription Agreement Form

The purpose of this agreement is to protect your access to controlled substances and protect our ability to Prescribe for you.

The long-term use of such substances as opioids (narcotics, analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of the risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial or continued prescription of a controlled substance to treat your acute or chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy you have selected is:

Pharmacy Name:_____Pharmacy Phone Number: _____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professional who provide your health care for purpose of maintaining accountability.
5. You may not share, sell or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescriptions. They should not be left where others might see or otherwise have access to them.
9. Prescriptions will not be filled earlier than the refill date. There will be no refills over the weekend, or after office hours.
10. I give consent for my physician to use Surescripts to view my prescription history.

I have read and understood all of the terms set forth in this agreement. I have been given a chance to ask and have all my questions answered to my satisfaction. By signing this form voluntarily, I agree to everything which has been set forth in this agreement.

_____ _____

Print Name Patient signature

BROOKLYN PREMIER ORTHOPEDICS

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Daniel Popowitz, DPM

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Jennifer Conenna, RPA-C
Lauren Roop, PA-C
Kathy Migliore, PA-C

*DATE:*_____

Consent for Chronic Opioid Therapy.

Dr. _____ is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of _____

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.
I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included:

_____

_____

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge

I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

(Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient signature_____Date_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- □ Medical Record form (insert date) _____to (insert date)_____
- □ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- □ Other:_____
  _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**
_____ **Genetic Testing**

Authorization to Discuss Health Information

(b). □ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm or Governmental Agency Name)

10. Reason for release of information: □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

NOTICE TO PATIENTS

New York State law prohibits medical providers, with certain exceptions, from referring patients for clinical laboratory services, pharmacy services, radiation therapy services, or x-ray or imaging services to a facility in which the medical provider or any immediate family members have a financial interest. If certain of the exceptions in the law apply, or if the referral is for other than clinical laboratory, pharmacy, radiation therapy, or x-ray or imaging services, the medical provider can make the referral so long as they disclose this financial interest and offer the patient about alternative providers where the patient may go to obtain these services.

This disclosure is intended to help you make a fully informed decision about your health care.

I or my immediate family members have a financial relationship with the following providers:

Advanced Recovery Equipment & Supplies

For more information about alternative providers, please ask me or my staff. We will provide you with names and addresses of providers best suited to your individual needs that are nearest to your home or place of work.

PRINT NAME_____ SIGNATURE_____

DATE_____

Brooklyn
PREMIERORTHOPEDICS

Media Release Form for Patient

PROJECT NAME/CLIENT:

Testimonial Consent
It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your physician.

1.1 INTRODUCTION
Medical photographs/slides, videotapes/audiotapes and print advertising may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs/slides, videotapes/audiotapes and/or print advertising for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES/AUDIOTAPES/PRINT ADVERTISING/BLOGS

I hereby authorize _____(Physician), and/or his/her associates or licensees to take pre-operative and post-operative photographs/slides, videotapes/audiotapes and/or print advertising. I additionally consent to photographs/slides, videotapes/audiotapes and/or print advertising/social media of my interview.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS /SLIDES/VIDEOTAPES/AUDIO-TAPES/PRINT ADVERTISING/BLOGS

I hereby authorize _____(Physician), and/or his/her associates or licensees to use pre-operative and post-operative photographs/slides, videotapes/audiotapes and/or print advertising for professional medical purposes deemed appropriate including, but not limited to, showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that my documents and name may be released to mass media including, but not limited to, network television and/or electronic digital networks, for future filming to be televised and/or printed. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my likeness or my testimonial appears.

I hereby hold harmless and release Physician and third party working with BPO from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Date: _____

Patient Signature: _____

Email: _____

Phone: _____

Witness: _____