

Orthopaedic Surgery
Pediatric Orthopaedic Surgery

ROBERT L. CRISTOFARO, M.D.
JOHN M. NELSON, JR., M.D., P.C.

PATIENT NAME _____ DATE OF BIRTH _____

PARENT/GUARDIAN NAME (IF MINOR) _____ DATE OF BIRTH _____

ADDRESS _____ SEX: MALE FEMALE (circle)

CITY/STATE/ZIP CODE _____ HOME PHONE () _____

EMPLOYER _____ CELL PHONE () _____

ADDRESS _____ WORK PHONE () _____

.....
PART OF BODY TO BE EXAMINED _____

PRIMARY CARE PHYSICIAN _____ TELEPHONE _____

ADDRESS _____

HOW WERE YOU REFERRED TO THIS OFFICE? _____

IS CONDITION A RESULT OF AN ACCIDENT? WORK _____ CAR _____ SCHOOL _____

DATE OF ACCIDENT _____
.....

PRIMARY INSURANCE COVERAGE INFORMATION

MEDICAL INSURANCE COMPANY _____

POLICY HOLDER'S NAME _____ DATE OF BIRTH _____

POLICY # _____ GROUP# _____

SOCIAL SECURITY # (PATIENT) _____

SOCIAL SECURITY # FOR PARENTS: MOTHER _____ FATHER _____

SECONDARY INSURANCE INFORMATION

MEDICAL INSURANCE COMPANY _____

POLICY HOLDER'S NAME _____ DATE OF BIRTH _____

POLICY # _____ GROUP# _____

TODAY'S DATE _____ PATIENT NAME _____

BIRTH DATE _____

PLEASE CIRCLE ANSWERS

ARE YOU RIGHT OR LEFT HANDED? (circle) RIGHT LEFT

OCCUPATION _____ ARE YOU WORKING NOW? YES NO

IF NO, WHEN DID YOU LAST WORK? _____

ARE YOU UNDER THE CARE OF ANY OTHER SPECIALIST? (Please list) _____

CHIEF COMPLAINT/WHAT ARE YOU HERE FOR? _____

PLEASE RATE YOUR PAIN ON A SCALE OF 1-10 (1=MILD, 10=UNBEARABLE) _____

WHEN DID THE PROBLEM START? _____

HOW DID IT START? (INJURY, SLOWLY, SUDDENLY) _____

IF INJURY: WAS IT RELATED TO A WORK ACCIDENT? YES NO

WAS IT RELATED TO A MOTOR VEHICLE ACCIDENT YES NO

DATE OF INJURY _____

HAVE YOU HAD ANY TREATMENT? YES NO

MEDICATIONS TAKEN _____

PHYSICAL THERAPY? YES NO FOR _____ WEEKS

CORTISONE INJECTION? YES NO IF YES # OF INJECTIONS _____

HAVE YOU HAD ANY TESTS FOR THIS PROBLEM? YES NO

IF YES, CIRCLE ALL THAT APPLY XRAYS CAT SCAN MRI NERVE STUDIES BLOOD STUDIES

PAST MEDICAL HISTORY: DO YOU HAVE ANY OF THE FOLLOWING? (CIRCLE ALL THAT APPLY)

DIABETES THYROID DISEASE HIGH BLOOD PRESSURE ASTHMA STROKE

ULCERS GOUT BLEEDING TENDENCY HEART DISEASE

ARTHRITIS LIVER DISEASE KIDNEY DISEASE HEARING IMPAIRED

THYROID DISEASE

CANCER: IF CIRCLED PLEASE DESCRIBE _____

PAST SURGICAL HISTORY: HAVE YOU HAD ANY SURGERY AT ANY AGE? YES NO

IF YES PLEASE LIST WITH DATE _____

MEDICATIONS: ARE YOU CURRENTLY TAKING MEDICATIONS OR HERBAL SUPPLEMENTS? (include over the counter) YES NO

MEDICATION DOSE/FREQUENCY

1. _____ 3. _____

2. _____ 4. _____

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATION? YES NO

IF YES, WHAT REACION TO WHAT MEDICATION DID YOU HAVE?

MEDICATION

REACTION

PATIENT NAME _____ DATE OF BIRTH _____

ARE YOU ALLERGIC TO LATEX (RUBBER PRODUCTS)? YES NO

SOCIAL HISTORY: DO YOU SMOKE? YES NO IF YES HOW MUCH? _____ PACKS PER DAY

DO YOU DRINK ALCOHOL? YES NO IF YES HOW MUCH? _____ PER DAY/WEEK

DO YOU TAKE ADDICTIVE DRUGS? YES NO IF YES, WHAT _____

FAMILY HISTORY: DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

CIRCLE ALL THAT APPLY

DIABETES SICKLE CELL GOUT HEART DISEASE
CANCER ARTHRITIS HIGH BLOOD PRESSURE BLEEDING DISORDERS

OTHER KNOWN FAMILY DISEASE _____

IS YOUR MOTHER ALIVE YES: AGE _____ NO AGE AT DEATH _____

IS YOUR FATHER ALIVE YES: AGE _____ NO AGE AT DEATH _____

REVIEW OF SYSTEMS: DO YOU HAVE ANY OF THE FOLLOWING (circle all that apply)

FEVER, WEIGHT CHANGE (INCREASE, DECREASE) # OF LBS _____ IN _____ MONTHS

FATIGUE, APPETITE CHANGE (INCREASE, DECREASE)

EYES: DOUBLE VISION, BLURRING VISION, TRAUMA, GLASSES

ENT & MOUTH: DEAFNESS, SINUSITIS, RINGING IN EARS, DIZZINESS
CARDIOVASCULAR: CHEST PAIN, PALPATATIONS, CALF PAIN WHILE WALKING,
IRREGULAR HEART BEATS

RESPIRATORY: SHORTNESS OF BREATH, WHEEZING, COUGH, COUGHING BLOOD

GI: DIARRHEA, CONSTIPATION, ABDOMINAL PAIN, VOMITING, BLOODY STOOL

GU: HESITANCY, INCONTINENCE, PAIN ON URINATION, FREQUENT URINATION
MENSTRUAL PROBLEMS, PREGNANCY

MS: OLD FRACTURE, SPRAINS, JOINT PAIN, JOINT SWELLING, ARTHRITIS, STIFFNESS,
ATROPHY

SKIN: CHANGE IN COLOR OR TEMPERATURE, RASHES, LESIONS, SCARS, MASSES, ULCERS,
DERMATITIS, ECZEMA

NEURO: PROBLEMS WITH SPEECH OR SWALLOWING, STROKE, CHANGES IN SENSATION,
SEIZURES, WEAKNESS, VISUAL CHANGES, BALANCE, MEMORY, COORDINATION,
NUMBNESS/TINGLING IN EXTREMITIES

PSYCH: DEPRESSION, MOOD CHANGES, HALLUCINATIONS, SLEEP DISTURBANCES

ENDOCRINE: EXCESSIVE THIRST, HYPER/HYPOACTIVITY, GROWTH/HAIR CHANGES

HEMATOLOGIC/LYMPHATIC: BLEEDING TENDENCY, LYMPH NODE, PAIN/ENLARGEMENT,
ANEMIA

MD SIGNATURE DATE _____

MD SIGNATURE DATE _____

MD SIGNATURE DATE _____

ORTHOPAEDIC SURGERY
PEDIATRIC ORTHOPAEDIC SURGERY
SCOLIOSIS AND SPINAL DEFORMITY SURGERY

ROBERT L. CRISTOFARO, M.D.
JOHN M. NELSON, JR., M.D., P.C.

3010 WESTCHESTER AVENUE, SUITE 104
PURCHASE, NY 10577

(914) 967-8708
(914) 967-5834 FAX

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.

Effective March 4, 2003

The privacy of your medical information is important to us. You may be aware of the U.S. government regulators established a privacy rule ("HIPPA") governing protected health information. This notice tells you about how it may be used and about certain rights you have.

Jennifer Acunto, privacy officer is in charge of privacy matters in our office. You can contact her at (914) 967-8708 if you desire further information, or if you have any questions or concerns.

USE AND DISCLOSURE OF PROTECTED INFORMATION

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist.

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. For example, under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. For example our accountants may see your name, dates of treatment and procedure codes during audits of our books.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. required by law
2. required for public health purposes
3. required by law to report child abuse
4. where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Professional Medical Conduct
5. required by law in judicial or administrative proceedings
6. required for law enforcement purposes by a law enforcement official
7. required by a coroner or medical examiner
8. permitted by law to a funeral director
9. permitted by law for organ donation purposes
10. permitted by law to avert a serious threat to health or safety
11. permitted by law and required by military authorities if you are a member of the armed forces of the United States
12. research purposes

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow

New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on an answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. You may contact *Jennifer Acunto* *privacy officer* for instructions on how to do so.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

RIGHTS YOU HAVE

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee may be charged).

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for disclosures we make to you, or to carry treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law [or for research or public health purposes after being de-identified or limited to remove personally identifiable information] or disclosures made before April 14, 2003.

If you received this notice electronically, you have the right to obtain a paper copy from our office.

OBLIGATIONS THAT WE HAVE

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to : Jennifer Acunto, Privacy Officer, 3010 Westchester Avenue, Suite 104, Purchase, NY 10577 (914) 967-8708.

No retaliatory action will be taken against you for any complaint you may make.

Robert Cristofaro, MD
John M Nelson, MD

PATIENT NAME _____ DATE OF BIRTH _____

ACKNOWLEDGEMENT FORM

HIPPA/RELEASE

I _____, have received a copy of the Privacy Practices and authorize the release of any information concerning my (or my child's) examinations and/or treatment provided for the purpose of evaluating and processing of claims for insurance benefits.

Signature of patient/guardian

date

PARTICIPATING AND NON-PARTICIPATING INSURANCE AGREEMENT

I, _____, recognize and accept personal responsibility for any balance remaining after payment of insurance benefits. I understand that if payment is not made in a reasonable amount of time (three months) I may be charged interest and/or a collection fee. (EXCEPTION TO PARTICIPATING INSURANCE COMPANY AGREEMENTS). I understand and accept that copayments are due at the time of service and a \$10.00 (ten dollar) surcharge will be applied for non-payment of copayment. I understand that if I am seen under my private insurance and then want to use Workers' Compensation or No-Fault benefits there will be no back billing or refunding of copayments. I understand that if I am a private pay patient that payment is due at the time of service unless financial arrangements have been made with this office.

Signature of patient/guardian

date

WORKERS' COMPENSATION/NO FAULT PATIENTS

I, _____, recognize and accept that I must provide current and valid Workers' Compensation/No Fault billing information at the time of service. I understand that such information is to be provided at the time of service and that any missing information is to be provided within 3 days of treatment. In the event that the insurance carrier has closed or not accepted such claims I will be financially responsible for such charges.

Signature of patient/guardian

date