Patient Registration Form (please print) **Suffolk Rehabilitation Medicine, PLLC. Mike M. Pappas, D.O.**

Last Name_____ First Name _____MI_____

Street Address_____Apt#_____City_____State_____Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____

Emergency Contact_____ Relationship_____ Phone ( ) _____

Social Security# _____Date of Birth____/____/____ Sex □M □ F

Reason for initial visit_____

Name of Referring Doctor/Person_____ Address _____

City_____ State_____ Zip_____ Ref Doctor Phone # _____

Family Physician_____ Phone # _____

Name of Employer_____Address_____

City_____ _____State _____ Zip _____Phone# _____

May we contact you at work □Yes □No

Primary Insurance Name _____Phone # _____

Policy # _____Group # _____Co-pay amt$ _____ Effective date ____/____/___

Name of Insured _____ Relationship to patient □Self □Spouse □Child □other

Insured Date of Birth _____/_____/_____ Insured Social Security #_____

Secondary Insurance Name _____Phone # _____

Policy # _____Group # _____Co-pay amt$ _____ Effective date ____/____/___

Name of Insured _____ Relationship to patient □Self □Spouse □Child □other

Insured Date of Birth ____/_____/_____ Insured Social Security#_____

□Workmans Compensation □No Fault Claim # _____

Attorney Name/Address_____

Attorney Phone #_____Fax# _____ Contact Person _____

1) I authorize the release of my personal information necessary to process my insurance claim(s) to Suffolk Rehabilitation Medicine, PLLC
2) I authorize and request payment of medical benefits directly to my physician, Dr. Mike M. Pappas, Suffolk Rehabilitation Medicine, PLLC
3) I agree that a photocopy of this form may be used as the original
4) I agree to pay all charges not covered by my insurance carrier. These charges include but are not limited to deductible co-payments, co-insurance and non-covered service.

_____ _____

Patient/Authorized Signature ***Date***

MIKE M. PAPPAS, D.O. SUFFOLK REHABILITATION MEDICINE, PLLC

Name_____ Age_____ Appointment Date _____

Referring Physician_____ Primary Physician_____

Reason for visit?_____ When did it start?_____

What makes it worse?_____ Better?_____

What was the injury or cause of your pain _____

On a scale of 1-10 (10 being the worst) what is your pain level?_____

Circle any of these that describe your pain: Dull Sharp Burning Shooting Aching

Is your pain or injury associated with any of the following? Weakness Numbness Tingling

Have you had any of the following symptoms recently?

Changes in bowel/bladder habits Fevers Chills Recent Weight loss

Circle which factors make your pain/injury better

Sitting Standing Walking Bending Lying Down Driving Coughing/Sneezing

Circle which factors make your pain/injury worse

Sitting Standing Walking Bending Lying Down Driving Coughing/Sneezing

List other doctors that have treated this condition _____

List any testing you have had for this injury:

X-ray _____date_____ results_____

MRI_____date_____results_____

Nerve testing_____date_____results_____

Other_____

Circle any treatments you have had for this injury in the past:

Physical therapy Chiropractic Acupuncture Massage Injections_____

List any medications you have taken for this injury_____

Is this a work related injury? Yes No

Past Medical History

Do you have any of the following conditions?

Any contagious disease	Yes	No	Thyroid Disease	Yes	No
High Blood Pressure	Yes	No	Bleeding Problems	Yes	No
Diabetes	Yes	No	Suppressed Immune System	Yes	No
Heart disease	Yes	No	Cancer	Yes	No
Lung Disease (COPD/Asthma)	Yes	No	Stomach Ulcers	Yes	No
Kidney Disease	Yes	No	Seizure Disorder	Yes	No
Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No

If any of the above yes, please explain or if you have any other medical conditions please explain:

_____

_____

Previous Surgeries

_____
_____
_____
_____
_____

Medications- List all medications, dosages, and frequency

1._____ 6._____
2._____ 7._____
3._____ ___ 8. _____
4._____ 9._____
5._____ ___ 10._____

Allergies- _____

Social History

Marital Status Single Married Divorced Widowed

Occupation_____ **Currently** Full Time Part Time Retired Disabled

Tobacco Do you smoke- Yes No If yes, for how many years?_____ How many packs/day_____

Alcohol Do you drink alcohol- Yes No If so, how often? _____

Do you have any history of alcohol or drug addiction? Yes No

Review of Systems

In the past few months have you experienced any of the following symptoms or complaints?

Fever/Chills	Yes	No	Difficulty Controlling Bowels	Yes	No
Night Sweats	Yes	No	Difficulty Controlling Urine	Yes	No
Chest Pain	Yes	No	New Rashes or Blisters	Yes	No
Difficulty Breathing	Yes	No	Swelling of joints	Yes	No
Persistent Cough	Yes	No	Numbness	Yes	No
Constipation	Yes	No	Weakness	Yes	No
Diarrhea	Yes	No	Depression	Yes	No
Nausea	Yes	No	Anxiety	Yes	No
Sudden weight loss	Yes	No	Bleeding problems	Yes	No
Sudden weight gain	Yes	No	Recurrent infections	Yes	No
Visual Changes	Yes	No	Difficulty swallowing	Yes	No

Patient Signature_____ **Reviewed By _____D.O.**

Mike M. Pappas, D.O.
Suffolk Rehabilitation Medicine, PLLC
220 Fort Salonga Rd.
Northport, NY 11768

ASSIGNMENT OF BENEFITS FORM

Name of Insured (print)_____

Social Security#_____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed above (Suffolk Rehabilitation) for any services or equipment provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits payable to the related services or equipment to the organization, the Healthcare Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Healthcare Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by healthcare benefits. It is my responsibility to notify the organization of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print):

_____

Relationship to Insured:

_____

Signature of Insured or Parent/Guardian:

_____

Mike M. Pappas, D.O.
Suffolk Rehabilitation Medicine, PLLC
220 Fort Salonga Rd.
Northport, NY 11768

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_____ Date of Birth_____

Social Security#_____

I request and authorize_____ to
Release healthcare information of the patient named above to:

Name_____

Address_____

City_____ State_____ Zip Code_____

This request and authorization applies to healthcare information relating to the following

treatment, conditions, or dates: _____

_____

All Healthcare Information:_____

Other:_____

Yes No I authorize the release of any records regarding drug, alcohol, or

mental health treatment to the person(s) listed above.

Patient Signature_____ Date Signed_____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14th, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in this office.

What is this all about: Specifically, there are rules and restrictions on who may see of be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1) Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, as least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to the persons other then the office staff. You agree to the normal procedure utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2) It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, us mail or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentially rules of HIPPA.

4) You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5) You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6) Your confidential information will not be used for the purpose of marketing or advertising of products, goods, or services.

7) We agree to provide patients with access to their records in accordance with State and Federal Laws.

8) We may change, add delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9) You have the right to request restrictions in the use of your protected health information and to request charge in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

_____ _____

Patient Signature Date

NEW YORK STATE OF OPPORTUNITY | Workers' Compensation Board

Doctor's Narrative Report EC-4NARR

State of New York - Workers' Compensation Board

THIS FORM MAY ONLY BE SUBMITTED ELECTRONICALLY. DO NOT MAIL.

This form may be used to report the *first* time you treated the patient or to report *continuing* services. (To report permanent impairment, use Form C-4.3.) **Use this form only if attaching a detailed narrative report.** Please answer all questions completely and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization.

Load previously saved EC-4NARR data *Required Fields **Conditionally Required Fields** - Select (CR) for field requirements.

A. Patient's Information

1. *Last Name: _____ *First Name: _____ MI: ____
2. Social Security #: _____ 3. Home Phone #: _____
4. WCB Case # (if unknown leave blank): _____ 5. Carrier Case # (if unknown leave blank): _____
6.* Mailing Address: _____ Line 2: _____
   *City: _____ (CR) State: Select State (CR) Zip Code: _____ *Country: USA
7. *Date of injury/onset of illness: _____ 8. *Date of birth: _____ 9. *Gender: ○ Male ○ Female
10. *On the date of injury/illness what was the patient's job title or description:

_____

11. *On the date of injury/illness what were the patient's usual work activities:

_____

12. *Is the patient working now? ○ Yes ○ No 13. Patient's Account #: _____

B. Employer Information

1. Employer when injury occurred:
   *Company/Agency Name: _____
2. Employer Phone #: _____
3. *Employer Address: _____ Line 2: _____
   *City: _____ (CR) State: Select State (CR) Zip Code: _____ *Country: USA

C. Doctor's Information

1. *Your Last Name: _____ *First Name: _____ MI: ____
2. *WCB Authorization #: _____ 3. *WCB Rating Code: _____
4. *Federal Tax ID #: _____ The Tax ID # is the (check one): ○ SSN ○ EIN
5. *Office Address: _____ Line 2: _____
   *City: _____ (CR) State: Select State (CR) Zip Code: _____ *Country: USA
6. Billing Group / Practice Name _____

Fill Billing Address with Office Address

7. *Billing Address: _____ Line 2: _____
   *City: _____ (CR) State: Select State (CR) Zip Code: _____ *Country: USA
8. *Office phone #: _____ 9. Billing phone #: _____
10. Treating Provider's NPI #: _____ 11. *You are a (select one): ○ Physician ○ Podiatrist ○ Chiropractor

D. Billing Information

(CR) 1. Employer's insurance carrier: _____ ☐ Unknown

2. Carrier Code #: _____

(CR) 3. Insurance carrier's address: _____ Line 2: _____

(CR) City: _____ (CR) State: Select State (CR) Zip Code: _____ (CR) Country: USA

4. *Diagnosis or nature of disease or injury:

Line	*ICD10 Code	*ICD10 Descriptor
1		

Add Another ICD10 Code **Remove Last ICD10 Code**

Relate ICD10 codes above to Diagnosis Code column by line.

Dates of Service *From	*To	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies *CPT/HCPCS	Modifier 1	Modifier 2	*Diagnosis Code	*$ Charges	Days/ Units	COB	*Zip Code where service was rendered

Add Another Billing Row **Remove Last Billing Row**

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$0.00		

☐ Services were provided by a WCB preferred provider organization (PPO).

E. Doctor's Opinion

1. *In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ○ Yes ○ No
2. *Are the patient's complaints consistent with his/her history of the injury/illness? ○ Yes ○ No
3. *Is the patient's history of the injury/illness consistent with your objective findings? ○ Yes ○ No ○ N/A (No findings at this time)
4. *What is the percentage (0-100%) of temporary impairment? _____ %

This form is signed under penalty of perjury.

***Board Authorized** Health Care Provider - Check one:

○ I provided the services listed above.

○ I actively supervised the health care provider named below who provided these services.

(CR) Provider's Last Name: _____ First Name: _____ MI: ___

(CR) Provider's Specialty: _____

Board Authorized Health Care Provider:

*Last Name: _____ *First Name: _____ MI: ___

*Specialty: _____ Date: _____