BRANCH ORTHOPEDICS – NO FAULT

Name (Last, First, MI) ____

Date of Birth __________Age ________SS#______________Occupation________

Street Address_______________________City__________State_____Zip________

Phone#______________ (Cell)_______________ Sex M/F___Martial Status____

Present Employer______________________Address____________________

Employer Phone#_____________________

Spouse/Parent/Guardian Name:______________________Phone#___________

Parents Employer: Mother_________________________ Phone#___________

Fathers Employer:_______________________________ Phone#___________

Emergency Contact Name:__________________________ Phone#___________

Primary Care Physician:___________________________ Phone#___________

Address:____

Referring Physician Name:_________________________ Phone#___________

Address:____

Date of Motor Vehicle Accident:______________________

Insurance Policy Holders Name:____

Insurance Company Name:____

Address:____Phone#___________

Policy#________________________________File#___________________

Was the accident reported to your Insurance Company? Yes_______ No_________

Were you hospitalized? Yes ______ No_______

Name of hospital & Address____

Dates of hospitalization___________________

Were you disabled by this accident? Yes__________ No____________

Date disability began__________________________

Attorney Name:________________________Phone#______________________

(SHOULD NO FAULT BE DENIED)

Private Insurance:____

Address:_________________________________Phone#___________________

Policy holder's name:____

Group#_____________________________ID#_________________________

Emergency contact:_____________________________Phone#_______________

NOTE: In consideration of services rendered or to be rendered to the above named patient, I hereby authorize and assign payment directly to Dr. Finuoli, provider of health services. I authorize the provider to release all medical information necessary to substantiate a claim. In the event that the provider does not receive payment from the insurance company, due to denial for any reason, I understand that I am personally responsible for payment of the provider's charges. I also understand that if I have not yet met my deductible under no-fault, that I am responsible for payment as such deductible, under my policy coverage.

Patient signature_________________________________Date_______________

Signature:______________________________________ Date_______________

(If signed by any other claimant, print below: Name, Phone # and relationship to signer).

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT:
1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME

2. PHONE NOS. HOME BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)

4. DATE OF BIRTH

5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.

7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT:

9. DESCRIBE YOUR INJURY:

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME | MAKE | YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

11.	YES	NO
WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: ____________

HOSPITAL'S NAME AND ADDRESS: ____________

14. AMOUNT OF HEALTH BILLS TO DATE: $ ____	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? YES ☐ NO ☐	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
17. DID YOU LOSE TIME FROM WORK? YES ☐ NO ☐	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: ____	AMOUNT OF TIME LOST FROM WORK: ____

18. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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 OR PERSONAL 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, SOLICITS 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.

SIGNATURE ______________________ DATE ______________

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) ______________________ SOCIAL SECURITY NO. ______________

SIGNATURE ______________________ DATE ______________

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) ______________________

SIGNATURE ______________________ DATE ______________

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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

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

Claim Number:__________________

I, ________________________, ("Assignor") hereby assign to Branch Orthopedics, ("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
(Print accident date)
to the contrary.

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 OR PERSONAL 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, SOLICITS 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)

Anthony Finuoli, DO
(Print name of Provider)

(Signature of Provider)

1092 Jericho tnpk
1st Floor
Commack NY 11725
(Address of Provider)

____
(Date of signature)

NYS FORM NF-AOB (Rev 1/2004)

BRANCH ORTHOPAEDICS
Anthony L. Finuoli, D.O., F.A.A.O.S.
Charles P. Brogan, RPA-C
Tyler Mannino, PA

1092 Jericho Turnpike
Commack, NY 11725

Patient Name: ______________________________________ **Male__Female__Ht: ____Wt____**

Address: ____

Phone Number: (home) ______________________**(cell)** ___________________________________

Date of Birth:___________ **Chief Complaint:** ____

Primary Insurance ____________________ **Member ID #**_________________**Group#** ________

Policy Holder_________________ **Relationship**__________________ **Date of Birth**___________

Do you use tobacco? Daily: _____ **Former Smoker:**____ **Never Smoked:** _______

Do you drink alcohol? Daily:____ **Occasionally:**____**Rarely:**____**Never:**_____

Marital Status: Married ____**Single** ____**Divorced**____ **Widowed**____ **Domestic Partner**____

Is your problem the result of an injury or accident? Yes___ **No**___ **Are you working?**______

If yes, Auto Accident _____ **Work Injury** ___________ **Attorney** ___________________________

Preferred Pharmacy and Location:____

List all medications: ____

Are you taking Blood Thinners (Aspirin, Plavix, Coumadin, Eliquis): Yes______ **No** _____

Do you have any allergies? Yes ____ **No**_____ **if yes, please list:**___________________________

____

Referral Source: Doctor (PCP) __________________________ **Other:**______________________

List all previous hospitalizations/surgeries: ____

List all personal/family health history/conditions:

____

Patient Signature:___________________________________**Date:**_____________________

BRANCH ORTHOPAEDICS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By my signature, I hereby acknowledge receipt of this Notice of Privacy Practices and I acknowledge that Branch Orthopaedics will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me and conducting health care operations.

I understand that I may request in writing that Branch Orthopaedics restricts how my private information is used or disclosed. I also understand that in providing treatment, Branch Orthopaedics my need to disclose my protected health information to the following:

Name: ______________________________ Relationship to me:________________________

Phone:______________________________

Name: ______________________________ Relationship to me: ________________________

Phone: ______________________________

Signature of patient/parent/guardian: ____

FINANCIAL POLICY

It is the expectation that all patients receiving services are financially responsible for the timely payment of all charges incurred. While our office will file with your verified insurance company for payment, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the terms of their insurance contracts. It is the patients/guarantors responsibility to be aware of their insurance contract as far as referrals, copayments, co-insurance and deductibles. Copayments are due at the time the service is rendered. For self-pay patients, we accept only cash or credit card, which is due upon arrival.

We do not become involved in third party liability matters. There will be a $50 fee incurred for any appointments that are missed without a call to our office 24 hours prior to the appointment time. Should you receive a payment from your insurance company which is intended for the doctor for services rendered, you must forward the payment to us. Please keep in mind, it is unlawful to keep these payments and legal action will be taken.

PATIENT SIGNATURE ____

BRANCH ORTHOPAEDICS
1092 Jericho Turnpike
Commack, NY 11725
Tel: 631-360-6370 Fax: 631-360-6373

Anthony Finuoli, D.O. Charles Brogan, RPA-C Tyler Mannino, PA-C

PAIN MEDICATION (NARCOTICS) POLICY

The physicians at Branch Orthopaedics understand that many orthopedic conditions, specifically fractures and surgical procedures may require narcotic pain medication to help control pain. **Narcotic medications have many side effects, the most serious being that they can be very addictive**. Other side effects include, but are not limited to, confusion, nausea, vomiting, constipation, fatigue and unsteadiness. Excessive doses of Tylenol, which contains Acetaminophen (found in many medications) may cause liver and kidney damage. Therefore, our physicians are very careful when prescribing these medications: Please read the following policy:

1) **All medication should be taken as instructed by your doctor.**

2) **Narcotic prescriptions will not be called to pharmacy for undiagnosed pain.**

3) **Patients with chronic pain and /or pain beyond that which is normally expected for a specific condition will be referred to a Pain Management doctor.**

4) **For prescription refills, you must call our office before 3PM.**

5) **No prescriptions will be filled at night or on weekends.**

****Effective 8/27/13, NEW YORK STATE LAW I-STOP** mandates all physicians to check patient's prescription history of narcotics. As such, prescribing pain medication will be monitored and altered accordingly.

Patient Name (PRINT) ______________________________

Patient Signature ____________________________ Date____________________