WORKER COMPENSATION INFORMATION

Date:_____

Patient Information

Name:_____ Birthdate:_____ Soc. Sec.#_____

Address:_____
Street City State Zip

Home phone:_(___)_____ Cell phone:_(___)_____ Occupation:_(___)_____

PLEASE CHECK HAND DOMINANCE: right _____ left _____

On the date of the injury/illness what was your job title or description?

_____

On the date of the injury/illness what were your usual work activities?

_____

Employer

Employer Name:_____

Employer Address:_____

Employer Phone: (___)_____ Injury Verified by _____

Contact Person:_(___)_____ E-mail:_____

Worker Compensation Carrier

Workers Compensation Carrier:_____

Carrier Address:_____
Street City State Zip

Carrier Phone: _(___)_____ coverage Verified by:_____

Adjuster's Name:_____ Claim Number: _____

Injury Information

Date of Injury: _____ Time: _____ ____AM ____PM Place of injury_____

Accident reported to employer? ____ Yes ___ No Name of person you reported accident to:

_____

Give full description of how accident happened?

_____

_____

_____

_____

Have you lost time from work? ___ yes ___ No How much? _____

Other doctors seen for this condition? (Doctor's Name)_____

Diagnosis: _____ Were x-rays taken? ____ yes ____ No Other tests? ____ Yes ____ No

If yes, by whom? Please list test (s) and result (s)

_____

_____

_____

_____

Any previous Workers Compensation injures: ___ Yes ___ No Date (s) of previous injuries:

_____

Describe previous Workers Compensation injuries: _____

Name/ Address/ phone of attorney:

_____

_____

Authorization

I clearly understand and agree that all services rendered to me are charged directly and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied. I understand that filing for Workers Compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of patient, patent/guardian or personal representative date

_____ _____

Please print name Relationship to patient

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_____