Orlin&Cohen Orthopedic Group
An affiliate of Northwell Health

MRN #: _____

Name: _____

CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

Consent to Treat

I authorize the medical and clinical staff, physical therapist, occupational therapist, speech therapist, neuropsychologist, their assistant's and other Northwell Health hospitals, Northwell Health Physician Partners ("NHPP") and associated physician locations (collectively, "Northwell") to provide care, including telehealth services, and to administer such diagnostic, radiological and/or therapeutic procedures and treatments as the medical staff determines is necessary or advisable in my care, or, for minor patients, in the care of my child. I authorize release of certain information including but not limited to immunization records to state and federal registries. If I am signing this document on behalf of another person, I acknowledge that I am consenting on behalf of the patient, and I will indicate my relationship to the patient where specified below.

I consent to be contacted by all phone numbers, whether landline or cellular, and email addresses provided regarding all matters pertaining to my medical treatment and payment for medical services. I also agree to receive text messages (including autodialed text messages) to the cell phone number provided for the purpose of communicating about my healthcare, including appointment reminders, information about billing and payment for medical services received. Message and data rates may apply. I acknowledge I can always text STOP to stop (a confirmation message will be sent) or HELP for help. The consents set forth in this paragraph extend to Northwell Health, the above-named facility, its contractors, and their subcontractors.

Assignment of Benefits

I hereby irrevocably assign and transfer to Northwell any monies or benefits to which I may be entitled, including benefits/monies from governmental payers such as Medicare, my insurance company, HMO, or other third parties who are financially responsible for my medical care. I authorize and direct Northwell and its physicians, having treated me, to release to such payers or other third parties who are financially responsible for my medical care, all information needed (including but not limited to medical records, copies of claims and itemized bills) to substantiate payment for my medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I understand that information disclosed for this purpose may include behavioral health and/or substance use disorder treatment information. I have the right to revoke my authorization for the release of this information for payment purposes at any time by writing to the above-named facility, except to the extent that action has already been taken in reliance on my authorization. I also appoint Northwell as my authorized representative to pursue all rights of payment, to ascertain the benefits available, to collect benefits directly from my insurance company and to appeal denials and proceed against my insurance company in any action, including legal suit, on my behalf if for any reason my insurance company refuses to pay my claim. The appointment shall include all rights to recover attorney's fees and costs for such action brought by Northwell as my assignee. I further agree to provide

VD141072 (03/09/2022)

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information as necessary and to cooperate with Northwell to process and obtain payments. This consent will expire after one (1) year or upon receipt of payment for medical services rendered, whichever is later.

Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release it to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers for the purpose of payment. I request that payment of authorized benefits related to my care be assigned to Northwell.

Guarantee of Payment

I understand that I am financially responsible for charges not covered by insurance. I agree to pay all amounts for which I am responsible for medical services rendered in accordance with the rates and terms of this practice or as determined by my health plan. Should the account be referred to an attorney for collection, I will pay reasonable attorney's fees and collection expenses.

I hereby authorize «Orlin & Cohen» clinical staff to speak to the following individual(s) regarding my condition:

	NAME	Relationship to patient	Initial
1.	: _____	_____	_____
2.	: _____	_____	_____
3.	: _____	_____	_____

Patient/Agent/Relative/Guardian* (Signature) _____ Date _____ Time _____ Print Name _____ Relationship if other than patient _____

Telephonic Interpreter's ID # _____ Date _____ Time _____

OR

Signature: Interpreter _____ Date _____ Time _____ Print: Interpreter's Name and Relationship to Patient _____

Witness to signature (Signature) _____ Date _____ Time _____ Print Witness Name _____

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of eighteen (18) or is otherwise incapable of signing.

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ACKNOWLEDGEMENT OF RECEIPT MRN #_____

I have received a copy of the Northwell Health's Notice of Privacy Practices.

_____

Signature of patient or personal representative

_____

Print name of patient or personal representative

_____

Date

_____

Description of personal representative's authority

_____

Department/location/site of visit

PROVIDER USE ONLY

☐_____Patient or patient representative refused to sign/accept Notice of Privacy Practices

☐_____Patient unable to sign

_____

Signature Date Time

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Name: _____ MRN#: _____

The following policies have been instituted so that patients, can receive the maximum benefit from their rehabilitation program:

Appointments - We make every effort to start your treatment at the time of your scheduled appointment. If you are waiting longer than 10 min to begin your treatment, we ask that you please notify the reception staff to facilitate the start of the appointment.

Attendance - You will receive the greatest benefit from your therapy by being consistent with your prescribed treatment program and by receiving care from your assigned therapy team (can include a physical therapist, physical therapist asst., occupational therapist, speech therapists). The frequency and duration of your treatment will depend on the recommendations of your physician, therapy team, personal schedule and time required to reach reasonable functional goals.

Lateness, No Show & Cancellations - Please call if you know that you will be late for an appointment or if you need to reschedule or cancel an appointment with more than 24 hours' notice. This allows your therapist to effectively manage their schedule and assist other patients. If you are 15 minutes late or more for an appointment the therapist has the discretion to determine if you can be seen that day and if lateness or no-shows become a frequent occurrence, you may not be permitted to book appointments in advance.

Co-payments - Copayments are due at the start of each treatment session. Your co-pay is decided by your insurance provider, and we are not permitted to waive co-payments. Authorization Coordinators are available to assist you with any questions regarding your co-payment. If you require a payment plan, you may speak with our billing department staff.

E-messages (text/email) – I accept that my healthcare provider (HCP) and I can terminate e-mail communication and/or text messaging at any time. I understand that I am responsible for notifying my (HCP) if I choose to discontinue email communications or text appointment reminders or if my contact information has changed. I __accept, __decline enrollment in appointment text reminders.

Resuming PT/OT/ST- To resume therapy after being discharged, a new prescription from your Physician is required. Additionally, your insurance provider may require you to obtain a new referral.

Acknowledgment Signature: _____ Date: _____

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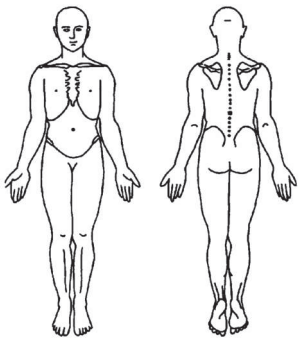
MRN #: _____

Patient Name _____ Date of Birth _____ Date _____
Address _____
Best Contact/s # _____ Occupation _____
E-mail Address _____
Activity Level/Sports/Hobbies _____
Family Doctor _____ Phone _____
Referring Doctor _____ Phone _____
Emergency Contact: _____ Phone _____

Please take your time to accurately complete. Detail will help your therapist with the evaluation.

I. Pain

1. Please mark picture where you have pain or other symptoms ⍰
2. Please describe your pain: (circle those that apply)
   - Localized or Radiating
   - Constant / Frequent / Intermittent
   - Sharp / Dull/Achy / Burning / Electrical / Throbbing
   - Deep or Superficial
   - Other: _____



3. Rate your pain perception on the following scale: 0 = No Pain; 1= Lowest, 10=Highest

Pain at Rest:	0	1	2	3	4	5	6	7	8	9	10
Pain w/Activity:	0	1	2	3	4	5	6	7	8	9	10

II. Symptoms

1. Date of injury/onset of symptoms _____
2. Cause of injury: ❑ Car Accident ❑ Work-related ❑ Sport ❑ None ❑ Other _____

_____

3. Symptoms at onset: _____

_____

4. Symptoms now: ❑ Same ❑ Better ❑ Worse _____

_____

Worse when: (circle all that apply) Bending, Sitting/Rising, Standing, Walking, Laying, Kneeling, Overhead Activities, Dressing, Other: _____

Better when: (circle all that apply) Bending, Sitting/Rising, Standing, Walking, Laying, Kneeling, Overhead Activities, Dressing, Other: _____

Previous treatment: ❑ Physical Therapy ❑ Chiropractic ❑ Massage ❑ Acupuncture
❑ Other: _____

Result of Treatment: _____

_____

What are your goals from therapy? _____

_____

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MRN #: _____

Patient Name _____ Date of Birth _____ Date _____

Medical Treatment Form (All Patients)

Past/Current Medical History

❑ No significant past medical history

❑ Arrhythmia
❑ Asthma
❑ Cancer
❑ Congestive Heart Failure
❑ COPD
❑ Coronary Artery Disease
❑ Depression
❑ Weakened Immune System
❑ Diabetes
❑ Fractures
❑ Heart Attack
Dates: _____
❑ Hypertension
❑ MS
❑ Mitral Valve Prolapse
❑ Other: _____
❑ Osteoporosis
❑ Pacemaker
❑ Currently Pregnant
❑ PVD (vascular disease)
❑ Rheumatoid Arthritis
❑ Stroke

_____

History of Falls: ❑ No ❑ Yes - If yes, how many in last 12 months? _____

History of: ❑ Smoking ❑ Alcohol ❑ Substance Abuse ❑ Other: _____

Family History of Current Condition: ❑ No ❑ Yes, Explain: _____
Other Significant Family History: ❑ None ❑ Cancer ❑ Heart Condition ❑ Other: _____
If yes, please explain: _____

Mental Health:
Over the past few weeks, have you felt little interest or pleasure in doing things? ❑ No ❑ Yes

Past/Current Surgical History

❑ No history of surgery

❑ Ankle surgery L / R
❑ Elbow surgery L / R
❑ Hand surgery L / R
❑ Knee Arthroscopy L / R
❑ Total Hip Replacement L / R
❑ Total Knee Replacement L / R
❑ Shoulder Replacement L / R
❑ Rotator Cuff L / R
❑ Bypass
❑ Cancer
❑ Pacemaker
❑ Spine

Other: _____

Medications (YOU MUST COMPLETE THE ATTACHED MEDICATION SHEET)

❑ Anti-Depressants
❑ Anti-Anxiety
❑ Blood thinners
❑ Steroids (i.e. Prednisone)
❑ Hypertension
❑ Diabetes
❑ Heart medication
❑ Pain Killers
❑ Anti-inflammatory
❑ Osteoporosis

Allergies: See attached sheet

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MEDICATION FLOW SHEET

MRN #: _____

PATIENT NAME: _____

DATE OF BIRTH: _____ **DATE OF EVALUATION:** _____

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

LATEX ALLERGY? ❑YES ❑ NO

❑ **NO MEDICATIONS TAKEN**

❑ **SEE ATTACHED LIST (ONLY IF ALL BELOW CRITERIA ARE MET)**

Please include ALL Medications you are taking including prescriptions, over the counters, herbals and vitamins/mineral/dietary.

MEDICARE PATIENTS MUST COMPLETE ALL COLUMNS (DOSE, FREQUENCY, ROUTE)

MEDICATION NAME	DOSE	FREQ.	Route of Administration (i.e., Oral, Injection, Sub-lingual)

Patient ID #_____PT/OT: Initials: _____Date: _____/_____/_____

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REGISTRATION FORM - SUPPLEMENTAL INFORMATION

Legal First Name: _____ **Legal Last Name:** _____

Date of Birth:_____ **Today's Date:** _____

Northwell Health provides leading edge care and world-class resources that meet the needs of all our patients. We strive to break down barriers and offer individualized, compassionate health care to each person. The following questions allow us to serve and promote the personal health and wellness of all our patients

Gender: What gender appears on your legal identification?

- ☐ Female
- ☐ Male

Birth Sex: What sex appears on your original birth certificate?

- ☐ Female
- ☐ Male
- ☐ Other/Intersex
- ☐ Withheld/Decline to Answer
- ☐ Same as above
- ☐ Withheld/Decline to Answer

Gender Identity: What is your current gender identity?

- ☐ Female
- ☐ Male
- ☐ Non-binary/GNC/Genderqueer
- ☐ Transfemale/Male to Female
- ☐ Transmale/ Female to Male
- ☐ Various Other
- ☐ Withheld/Decline to Answer

Please complete the following optional questions:

Name you prefer to identify with:

_____

(last name) (first name) (middle name)

Pronoun: Which pronoun should we use to refer to you?

- ☐ She/Her
- ☐ He/His
- ☐ They/Them
- ☐ Withheld/Decline to Answer