Orlin & Cohen Medical Specialists Group

Sports Medicine, Joint Replacement, Arthroscopy & Reconstructive Surgery, Foot & Ankle Surgery,
Knee & Shoulder Reconstruction, Spinal Surgery & Pain Management, Hand & Elbow Surgery, Trauma

Patient Label

NEW PATIENT INFORMATION FORM

LAST _____ M.I. _____ FIRST _____

STREET # & NAME OR P.O. BOX _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SS # _____ DOB _____ SEX _____ E-MAIL _____

NAME OF SPOUSE/PARTNER/GUARDIAN (EMERGENCY CONTACT) _____ PHONE _____

REFERRING PHYSICIAN NAME _____ ADDRESS _____ PHONE _____

PRIMARY CARE PHYSICIAN NAME _____ ADDRESS _____ PHONE _____

INSURANCE: PRIMARY _____ SECONDARY _____

INSURED _____ EMPLOYER _____ ADDRESS _____ INSURED DOB _____

CURRENT SCHOOL INCLUDES GRADE LEVEL _____ SPORTS/OCCUPATION INCLUDE POSITIONS _____

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports / Light Duty / Not working due to the Injury

Does this visit involve a workman's Compensation issue? YES / NO Hand Dominance: ❑ LEFT ❑ RIGHT

Was your injury reported to your employer ❑ Yes ❑ No

Chief Complaint / History of Present Illness: Height_____ Weight_____

Body Part Injured: LEFT / RIGHT_____ Cause: Sports/Work/Auto/Other

Date of Injury/Accident/Onset: _____ Time & Place _____

How did the Injury Occur?_____

_____ Was Injury ❑ Gradual ❑ Sudden ❑ Repetitive Motion

How does it affect / bother you?_____

Pain at Rest: (No Pain) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

Pain at Activity: (No Pain) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

Does anything make your pain better or worse? (Please list) _____

Have you been treated for this problem before? YES / NO Date(s):_____

By whom? _____

Prior surgery for this problem? YES / NO Date(s): _____

Physical therapy for this problem? YES / NO Date(s):_____

If you were/are unable to work/play, list dates of disability:_____ to _____

Have you had any prior tests or imaging studies for this problem? YES / NO

If yes, list facility, type & date: _____

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Past Medical History: (PHX) *Please list none if the question does not apply.*

Medical Problems: _____

_____

Previous Hospitalizations & Surgical Procedures: (Provide Dates) _____

_____

_____

Please list all allergies (drug, food, environmental): _____

_____

Current Medications: (Include Doses and Frequency) _____

_____

_____

Family Medical History: (Include Medical Illness Affecting Patient's Immediate Family)_____

_____

Social History: (Check Boxes and Fill Blanks)

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other:_____

Alcohol Use: ❑ Occasional ❑ Daily ❑ Heavy ❑ None

Tobacco Use: ❑ Yes ❑ No (Type:_____Packs Per Day_____Years Used:_____)

Recreational Drug Use: ❑ Yes ❑ No (Types):_____ _____)

REVIEW OF SYSTEMS: (Check All That Apply)

GENERAL
❑ Weight Change
❑ Fever or Chills
❑ AIDS/HIV
❑ Night Sweats
❑ Bleeding
❑ Lumps or Masses
❑ Dizziness or Fainting
❑ Diabetes Mellitus
❑ Thyroid Problem
❑ Cancer

EAR-EYES-NOSE-THROAT
❑ Visual Change
❑ Hearing Change
❑ Tinnitus
❑ Bleeding Gums

MUSCULOSKELETAL
❑ Back Pain
❑ Joint Pain
❑ Joint Swelling
❑ Neck Pain

GASTROINTESTINAL
❑ Difficulty Swallowing
❑ Jaundice
❑ Hepatitis
❑ Reflux
❑ Ulcer

CARDIOVASCULAR
❑ Chest Pain
❑ Heart Disease
❑ High Blood Pressure
❑ Mitral Valve Prolapse
❑ Thrombophlebitis/DVT/PE

RESPIRATORY
❑ Cough/Sputum
❑ Tuberculosis
❑ Shortness of Breath
❑ Asthma
❑ Emphysema

❑ All Systems Reviewed & Negative

GENITOURINARY
❑ Urinary Infections
❑ Incontinence
❑ Urinary Frequency
❑ Venereal Disease
❑ Menopause

NEUROLOGIC
❑ Seizures
❑ Numbness
❑ Weakness

PSYCHOLOGICAL
❑ Depression
❑ Bipolar
❑ ADD/ADHD
❑ Other

SKIN
❑ Itching or Rash
❑ Wound Discharge

Providers Notes Section:

Pharmacy Information Sheet

We can send your prescriptions directly to your pharmacy so that there is less waiting time for you. If you know your pharmacy, please complete the below form. Please be aware that the easiest way for us to find your pharmacy is to know the zip code.

Your Name:	Date of Birth:	
Pharmacy Name:		
Address:		
City:	State:	Zip:
Pharmacy Phone #:	Pharmacy Fax:	

_____ _____ _____ _____

Patient/Guardian Signature | Date | Physician's Signature | Date

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO.(IF KNOWN)	CARRIER CASE NO. (IF KNOWN)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.
		Injury Date		

CLAIMANT	Full Name	Address:
EMPLOYER	Company Name	Employer Address
INSURANCE CARRIER	Primary Plan Name	Current Job Title

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for servicesrendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible forpayment.

Claimant's Signature: _____ Date: _____

Provider's Name and Address:_____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative if you have one. You may also contact your local district office of the Workers' Compensation Board

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

Orlin & Cohen Rehabilitation Services

Attention: All Workers Compensation Patients

Dear Patient,

As per Workers' Compensation guidelines, you are subject to an initial approval period if you are being treated for a condition related to the neck, shoulder, low back and knee.

Neck, Back or Knee: 8 weeks from the start of care
Shoulder: Up to 12 weeks from the start of care
Carpal Tunnel Syndrome: 8 weeks from the start of care

If you are not being treated for a condition listed above, your rehabilitation approval must be obtained after your **Initial Evaluation Appointment**. Once your carrier approves your follow-up visits, our Authorization Department will call to inform you of your initial approval period.

At the end of each approval period, we are required to send a progress report and other medical information from your doctor. After all the required information is received, we will be informed if more visits are approved. Workers' Compensation has up to **30 days to respond to the request.**

What you can do to help:

1) Schedule a follow-up appointment with your referring doctor towards the end of your approval period. This will allow the doctor to complete the required documentation in a timely manner.

2) Keep in touch with your doctor's office to make sure they have completed and sent out the forms to your Workers' Compensation Carrier

Signature: _____ Date: _____

** Not applicable to Dept. of Labor / LIRR / NYPD / NYFD / NYC Sanitation Uniform Workers **

NEW YORK STATE | Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

CLAIMANTS ARE PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
(CLAIMANT'S NAME)

represent that I am a person who is/was the subject of the workers' compensation cases(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to _____,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at _____.
(ADDRESS)

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

_____ _____
Claimant's Signature (ink only - use blue ink if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one-hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.

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CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I understand that, in order for Orlin & Cohen to leave detailed messages containing specific health information on my voice mail or answering machine, I need to give permission for Orlin & Cohen to do so.

Consent for Leaving Messages

I give my permission for messages regarding the following to be left on my phone number(s) below:

Enter "Y" or "N".

____Appointment Reminders/Changes ____Account Payments/Balances ____Cost Estimates ____Needed Treatment/Completed Treatment ____Test Results

Cell # _____ Home # _____ Work #_____

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law, we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form. The name(s) listed below are family members or friends to whom I grant permission for Orlin & Cohen to verbally discuss my care using their best judgment and grant them permission to disclose information regarding the following (Enter Y or N):

_____Appointment Reminders/Changes _____Account Payments/Balances _____Cost Estimates _____Needed Treatment/Completed Treatment

_____Test Results

	NAME	RELATIONSHIP	PHONE NUMBER
1.	_____	_____	_____
2.	_____	_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

Printed Name (Patient/Parent)	Signature (Patient/Parent)	Date
_____	_____	_____

CONSENT TO E-MAIL AND TEXT COMMUNICATIONS

I consent to communicate with Orlin & Cohen through e-mail and/or text messaging. If I am signing this document for another person, I agree that I am consenting for this patient and I will provide the relationship (parent, relative, health care agent, guardian, surrogate) where indicated below. I agree that:

Text messaging will be used only for the purpose of providing me with appointment-related information. Text messaging may not be used to communicate with my healthcare provider. I understand that text messages will be sent unencrypted which means that they will not be protected and others may be able to access the information as it is sent.

I understand that e-mail communication should not be used for emergencies or for communicating time-sensitive information. E-mail communication will be processed during routine business hours.

In the event of a medical emergency, I should call 911 or go to the nearest Emergency Department. E-mail should be used only for non-urgent issues. It should not contain sensitive information such as information regarding sexually transmitted diseases, HIV/AIDS, mental health, developmental disabilities or substance abuse. I understand that any e-mail communication between my provider and me regarding my care my become part of my medical records.

By providing my e-mail address, I am agreeing to receive e-mails. Emails that are sent from Orlin & Cohen will be encrypted to keep them secure, unless I request to receive unencrypted e-mails. I understand that most personal e-mail services do not encrypt or otherwise protect e-mails. Therefore, there is a risk that e-mails I send from my e-mail account to my provider may be accessed by others not affiliated with my provider. As a result, I understand that if I communicate with my provider using my personal e-mail account, it may not be secure and there is a risk that my health information may be obtained by others not affiliated with my provider. Despite this risk, I authorize my provider to send my personal health information via e-mail.
I further acknowledge that e-mails and text messages may be subject to technical malfunctions. Therefore, I understand that e-mail and text message delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.

I accept that my healthcare provider or I can terminate e-mail communication and/or text messaging at any time.

I understand that I am responsible for notifying the healthcare provider if I choose to discontinue e-mail communications or text appointment reminders or if my contact information has changed. The contact information is used for the purposes of this form will be the most current information on file with Orlin & Cohen.

Request for Email Communication via Unencrypted Email Only
Orlin & Cohen strongly discourages communication sent without encryption. In addition to the risks identified above, sending e-mail unencrypted means others may be able to access the information and read it once it is transmitted over the internet. By signing below and authorizing unencrypted email, I acknowledge the risks to which my information may be exposed.

_____		_____	
Patient (Signature)	Date/time	Print name	
_____		_____	
Agent/Relative/Guardian (Signature)	Date/time	Print name	Relationship if other than patient

Date _____ Patient Name _____

PHYSICAL/ OCCUPATIONAL THERAPY CONSENT INFORMATION

CONSENT TO TREAT
This information I have given this office is complete and true to the best of my knowledge. I authorize the therapists or provider and staff of Orlin & Cohen Rehabilitation Services to administer such procedures and treatment as they deem necessary. The therapists or provider have implied no guarantee of cure.

Patients Initials_____ Date_____

CONSENT TO TREAT A MINOR CHILD
The information I have given this office pertaining to _____ is true and complete to the best of my knowledge. I authorize the therapists or provider and staff of Orlin & Cohen Rehabilitation Services to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The therapists or provider have implied no guarantee of cure.

Parent/Guardian Initials_____ Date_____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of information pertinent to my case to my insurance company, claims adjuster or attorney involved in this case.

Patients Initials_____ Date_____

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

Orlin & Cohen Rehabilitation Services
LB#7805, PO Box 95000
Philadelphia, PA 19195-0001

Patient/Guardian Signature _____ Date_____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I; _____, acknowledge that I have been provided with a copy of Orlin & Cohen Rehabilitation Services' HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information

_____

Signature_____ Date_____

HIPAA AUTHORIZATION TO RELEASE I authorize/give permission to the following people to receive my protected health information. List school, office etc…

_____Signature_____ Expiration Date: _____