MEDICAL CLINICS
OF NEW YORK CITY

Lien Patient Registration form

A DEMOGRAPHIC INFORMATION

Full Name *(Last, First, Middle)* :

Date of Birth : M M / D D / Y Y Y Y **Gender** : M Male F Female

Phone Number : **Social Security Number** :

Address :

City : **State** : **ZIP** :

Primary Doctor Name/Address :

Pharmacy Name / Address :

B INSURANCE INFORMATION

Insurance Carier : **Card Id#** :

Patient's Signature : **Today's Date** : M M / D D / Y Y

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MEDICAL CLINICS
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NOTICE OF DOCTORS LIEN

Patient's Name :

Date of Accident : M M / D D / Y Y

I do hereby authorize :

- Westchester Medical Care P.C.
- Total Neuro Care P.C.
- Pehlam Medical Care P.C.

to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.
I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honors this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

1 fully understand that I am directly and fully responsible to said doctor for all medical hills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and is consideration of his awaiting payment And I further understand that such payment is not contingent on any settlement, judgment or verdict by which may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's Interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient's Signature :
(if minor, parent/ guardian)

Date : M M / D D / Y Y

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs

Attorney Name :
(Last, First, Middle)

Attorney Signature

Today's Date : M M / D D / Y Y

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HEALTH INFO & BENEFIT AUTHORIZATION

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of health benefits to the selected provider below. I, hereby assign to,

- ☐ Westchester Medical Care P.C.
- ☐ Total Neuro Care P.C.
- ☐ Pehlam Medical Care P.C.

All rights, privileges and remedies which I am entitled under the state insurance law. Any patient pursuant to this assignment shall not exceed the health care provider's permissible charges.

Patient's Signature :
(if minor, parent/ guardian)

AUTHORIZATION FOR THE RELEASE OF HEALTH SERVICE AND TREATMENT INFORMATION

This authorization, or a 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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Patient's Signature :
(if minor, parent/ guardian)

Patient's Name :

Date : M M / D D / Y Y

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PATIENT DISCLOSURE CONSENT

The HIPPA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communications be made via alternative means such as sending information of the individuals place of employment instead of their home.

I CONSENT TO BEING CONTACTED IN THE WAYS LISTED BELOW:
(check all that apply)

- ○ Cell Phone Number: _____
  I agree to receive voicemails with specific and detailed content
- ○ Home Phone Number _____
  □ OK to leave a voicemail with detailed information
  □ Leave voicemail with callback number only
- ○ Work Phone Number _____
  □ OK to leave a voicemail with detailed information
  □ Leave voicemail with callback number only
- ○ Contact Person & Phone Number _____
  □ OK to leave a voicemail with detailed information
  □ Leave voicemail with callback number only
- ○ Email: _____
  I agree to receive emails

In accordance with privacy regulations, we are required to take reasonable steps to limit the use or disclosure of your personal information to the minimum necessary to achieve the intended purpose. Please note that in the event of an emergency, your information may be used or disclosed without prior consent.

Patient's Name :
(Last, First, Middle)

Patient's Signature :

Today's Date : M M / D D / Y Y

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MEDICAL CLINICS
OF NEW YORK CITY

AUTHORIZATION FOR RELEASE OF INFORMATION

A MUST BE COMPLETED FOR ALL AUTHORIZATION

I hereby authorized the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or care provider, the released of information may no longer be protected by federal privacy regulations.

Patient's Name :
(Last, First, Middle)

Date of Birth : M M / D D / Y Y Y Y **ID Number** :

Person/Organization(s) providing the information :

Person/ Organization(s) receiving the information :

Specific description of information (including date(s)): :

B MUST BE COMPLETED ONLY IF ARE HEALTH CARE PROVIDER HAS REQUEST OF THE AUTHORIZATION

The health plan or care provider must complete the following:

- What is the purpose of the use or disclosure?
- Will the health plan or care provider requesting the authorization received financial or in-kind compensation in exchange for using or disclosing the health information described above? Y Yes N No

The patient or the patient's representative must read and initial the following statement:

- I understand that my healthcare and the payment for my healthcare will not be affected if I do not sign this form. Initials
- I understand that I may see and copy the information described un this form if I ask for it, and that I get a copy of this form after I sign it. Initials

C MUST BE COMPLETED FOR ALL AUTHORIZATION

- I understand that this authorization will expired on M M / D D / Y Y Y Y
- I understand that I will revoke this authorization at any time by notifying the providing organization in writing. It won't have any effect on any actions they took before they received the revocation.

Representative's Name :

Relationship to patient :

Patient or Representative's Signature

Today's Date : M M / D D / Y Y

MEDICAL CLINICS
OF NEW YORK CITY

INFORMED CONSENT

Westchester Medical Care P.C.
2932 Wilkinson Avenue,
Bronx, NY - 10461

Total Neuro Care P.C.
1513 Voorhies Avenue,
Brooklyn, NY - 11235

384 East 149 Street, Suite 518, Bronx, NY 10455 • 3403 Broadway, NY, NY 10031 • 110 West 34th Street, Suite 400, NY, NY 10001
121-02 Hillside Avenue, Richmond Hill, NY 11418

I acknowledge that I have received information regarding my condition following a medical examination. I hereby request and consent to any additional procedures, including but not limited to tests, diagnostic evaluations, and physical therapy, that the provider named below recommends. This consent also extends to other licensed healthcare professionals who may now or in the future participate in my care.

I understand that, as with any healthcare procedure, there are potential risks and complications. While I do not expect the doctor or clinical staff to anticipate or explain every possible risk, I trust the provider's clinical judgment throughout the course of my treatment and rehabilitation. Possible risks may include, but are not limited to, muscle strains, sprains, fractures, dislocations, and burns.

I confirm that I have read, or had read to me, the above information and that I understand it. I have had the opportunity to ask questions regarding the proposed treatment, and all my questions have been answered to my satisfaction.

I also acknowledge that while every effort will be made to achieve the best possible outcome, no guarantees have been made regarding the results of the treatment or rehabilitation. I understand there may also be risks associated with not receiving the proposed care.

This consent is intended to apply to the entire course of treatment for my current condition, as well as for any future conditions for which I seek care.

Patient's Name *(Last, First, Middle)* :

Patient's Signature

Name of Patient's Representative :

Patient's Representative Signature

Today's Date : M M / D D / Y Y

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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121-02 Hillside Avenue, Richmond Hill, NY 11418

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding the privacy of my protected health information (PHI). I acknowledge that this information may be used and disclosed in order to:

- Conduct, coordinate, and manage my treatment, including follow-up care involving multiple healthcare providers who may be directly or indirectly involved in my care.
- Obtain payment from third-party payers.
- Perform routine healthcare operations, such as quality assessments, provider certifications, and administrative processes.

I acknowledge that I have received, read, and understand the Notice of Privacy Practices, which provides a detailed explanation of how my health information may be used and disclosed. I understand that this organization reserves the right to change its Notice of Privacy Practices at any time and that I may obtain the most current version by contacting the organization at the address provided above.

I understand that I have the right to request, in writing, that certain restrictions be placed on the use or disclosure of my health information for treatment, payment, or healthcare operations. I also understand that the organization is not required to agree to these restrictions. However, if it does agree, it is bound by that agreement.

Patient's Name *(Last, First, Middle)* :

Patient's Signature

Name of Patient's Representative :

Patient's Representative Signature

Today's Date : M M / D D / Y Y

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this notice of privacy practices acknowledgement, but was unable to do so as documented below:

Reason : _____

Date : _____

Initial : _____

MEDICAL CLINICS
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PAIN MANAGEMENT TREATMENT AGREEMENT

Westchester Medical Care P.C.
2932 Wilkinson Avenue,
Bronx, NY - 10461

Total Neuro Care P.C.
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Brooklyn, NY - 11235

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121-02 Hillside Avenue, Richmond Hill, NY 11418

I, _____, agree that Dr. _____ will be the only physician prescribing controlled substances/medication for me and that I will obtain all of my prescriptions for controlled substances at one pharmacy. I will not seek controlled substances from another physician.

- I will not take controlled substances in larger amounts or more frequently than is prescribed.
- I will not give or sell my medication to anyone else, including family members; nor will I accept any controlled substances from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication will not be replaced.
- I will not use over-the-counter codeine-containing medications such as Tylenol.
- I will attend all reasonable appointments, treatments, and consultations as requested by my physician.
- I understand that the long-term use of controlled substances to treat chronic pain may result in physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of controlled substance withdrawal. I understand that controlled substance withdrawal is uncomfortable but not life-threatening.
- I understand that there is a small risk that I may become addicted to the controlled substances I am being prescribed.
- I understand that my physician may, at any time, require that I have additional blood or urine monitoring and/or see a specialist in addiction medicine should a concern about addiction arise during my treatment. I will comply with all requests for laboratory tests including random urine monitoring ordered by my physician.
- I understand that the use of any mood-altering substance, such as tranquilizers, sleeping pills, alcohol, or illicit drugs (such as cannabis, cocaine, heroin, or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all of these substances without prior agreement from my physician.
- I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.
- I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances, and I may be discharged from this practice.
- I will comply with requests by my physician to go to the office for a pill count between scheduled visits.

Patient's Name *(Last, First, Middle)* :

Patient's Signature

Date : M M / D D / Y Y

Physician's Signature