MEDICAL CLINICS
OF NEW YORK CITY

Worker's Compensation

A PERSONAL 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** :

Referred By :

Pharmacy Name / Address :

B WORKER'S COMPENSATION INFORMATION

Employer Name :

Date of Injury : M M / D D / Y Y **Work Duties** :

WC Insurance Carrier : **Case Worker** :

WCB # : **Carrier Case #** :

Attorney's Name/ Telephone :

Are you working now? : Y Yes N No **Date you stopped working** : M M / D D / Y Y

Date you returned to work : M M / D D / Y Y

Please Note:

- Notify the front desk if your working status has changed.
- Notify the front desk if any of the above information has changed.
- Copy of C-4 will be mailed to Worker's Compensation Board
- Your attorney earn access your electronic file with Worker's Compensation Board.
- Copy of C-4 and medical records may be requested by patient in advance. Please allow 5
- to 7 days for processing. Please notify the front desk of your hearing date in advance.
- Please keep your appointments. If any changes, kindly notify us within 24 hours.
- Forms must be dropped in advance. Please allow 5-7 days for processing.

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

+1 (877) 465-7360
www.medicalclinicsofnyc.com

MEDICAL CLINICS
OF NEW YORK CITY

COVID-19 Screening Form

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

	YES	NO
Have you bad a cough, shortness of breath, difficulty breathing, fever (temp 100.5 Fahrenheit or greater) chills, unexplained repeated shaking with chills, muscle pain, unexplained headache, sore throat or new onset loss of taste or smell in the last 14 days?	☐ Yes	☐ No
Have you had close, unprotected, contact with a suspected or laboratory confirmed COVID-19 individual in the last 14 days?	☐ Yes	☐ No
Have had a laboratory confirmed or suspected diagnosis of COVID-19 in the past 14 days?	☐ Yes	☐ No
Have you or someone you had close contact with traveled to other states where COVID-19 cases have been spiking, internationally or been on a cruise in the last 14 days?	☐ Yes	☐ No

Please Note:

- New patients are encouraged to fill out paperwork in their vehicles if possible.
- Mouth and Nose coverings are mandatory for admission
- Guests/family of patients are encouraged to stay in their vehicles if possible.
- Upon entry please sanitize, have your temperature taken by staff and wash your hands. If you
- choose to wear gloves please put them on upon entry to lessen the likelihood of contaminants
- All staff and patients are encouraged to wash hands frequently
- Signs are posted on the ceiling to ensure social distancing

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

Patient's Signature :

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

+1 (877) 465-7360
www.medicalclinicsofnyc.com

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___-___-____ 5. Phone Number: (____)_____ 6. Gender: ☐ M ☐ F ☐ X

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: _____/_____/_____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/_____/_____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (_____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (_____)_____
5. Have you had another injury to the same body part, or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

An individual may sign on behalf of the employee only if they are legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____

Instructions for Completing Employee Claim (Form C-3)

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the end of these instructions. If you need additional help completing this form, contact the Workers' Compensation Board at **1-877-632-4996.** You may also fill this form out online at **wcb.ny.gov**. If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/ illness on the top of page two.

Section A - Your Information (Employee):

In Section A, enter your name, address and other requested information.
Note on Item 7: Board hearings are conducted in English. If you need a translator, select **Yes** and indicate the language needed.

Notification Pursuant to the New York Personal Privacy Protection Law
(Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a).

The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Section B - Your Employer(s):

In Section B, enter the name, address, phone number and other information of the employer you were working for at the time of the injury/illness.
Note: Your employer is the company or agency that issues your paycheck. If you are a contractor at a work site or office, the staffing agency or vendor who hired you is your employer, not the work site or office where you report to work.

Section C - Your Job on the Date of the Injury or Illness:

In Section C, enter your job title, work activities and pay information.

Section D - Your Injury or Illness:

In Section D, enter your injury or illness information.
Item 1: Enter the date you were injured or the first date you noticed you became ill.
If this is an illness or occupational disease, skip item 2. The date you were injured must be in month/day/year format. The year should be written as four digits, e.g., 2015.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now).
Item 8: Indicate if some object was involved in the accident **other than** a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier. **If you filed a Department of Motor Vehicles *Form MV-104 (Report of Motor Vehicle Accident)*, please submit a copy along with the C-3. This will expedite the process for you to receive potential benefits.**
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate the date you stopped working. If you have not stopped working, check No and skip to the next section.
Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)
Item 3: If you have returned to work, indicate who you are working for now.
Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.
Item 2: Check if you were first treated on the job for this injury or illness.
Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).
Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise, check No.
Item 5: If you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**
Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the nearest Workers' Compensation Board Office. (See below.) Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, telephone or visit the nearest Workers' Compensation Board Office listed below.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided they are authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed, the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, their fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:
New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205 Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996

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

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

+1 (877) 465-7360
www.medicalclinicsofnyc.com

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

MEDICAL CLINICS
OF NEW YORK CITY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 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
OF NEW YORK CITY

PAIN MANAGEMENT TREATMENT AGREEMENT

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, _____, 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

MEDICAL CLINICS
OF NEW YORK CITY

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

+1 (877) 465-7360
www.medicalclinicsofnyc.com