ORTHOMANHATTAN
485 Madison Avenue
8th Floor
New York, New York 10022

My appointment today is with:

- ☐ O. Alton Barron, MD
- ☐ Louis W. Catalano III, MD
- ☐ Adam B. Cohen, MD
- ☐ Steven Z. Glickel, MD
- ☐ Jonathan R. Stieber, MD
- ☐ Roy I. Davidovitch, MD

PATIENT REGISTRATION

PATIENT DEMOGRAPHIC INFORMATION

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

GENDER: MALE ☐ FEMALE ☐ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ APT/SUITE: _____

CITY: _____ STATE: _____ ZIPCODE: _____

HOME PHONE: _____ WORK PHONE: _____ MOBILE PHONE: _____

EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHONE #: _____

PHARMACY ADDRESS: _____

MEDICAL CONTACT INFORMATION

REFERRING PHYSICIAN: _____ REF. PHYSICIAN PHONE #: _____

PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT:

NAME: _____ CONTACT #: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

INSURANCE: _____
MEMBER ID: _____
GUARANTOR: _____
GUARANTOR DOB/SS#: _____
SECONDARY INSURANCE: _____
MEMBER ID: _____

WORKER'S COMPENSATION OR NO FAULT

DATE OF ACCIDENT: _____
INSURANCE CO. NAME: _____
INSURANCE PHONE: _____
POLICY #: _____
INSURANCE REP: _____
CASE#: _____

HOW DID YOU FIND US?

REFERRING PHYSICIAN: ☐ FRIEND: ☐ SOCIAL MEDIA: ☐ AD: ☐ INTERNET SEARCH: ☐

OTHER: _____

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PATIENT REGISTRATION

PATIENT NAME _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have Insurance coverage and assign all physicians of OrthoManhattan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. This may include any deductible, co-pay or co-insurance for which I am responsible, and any non-covered items. I hereby authorize OrthoManhattan to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, have been informed that the U.S. Government requires I sign this *Notice of Privacy Practices.* The privacy regulations were created by the *HIPPA Act of 1996* to protect patient privacy. I understand that the full text of the Act is available to me upon request.

SIGNATURE: _____ DATE: _____

CANCELLATION POLICY

I, the undersigned, understand that as a patient at OrthoManhattan I must cancel my appointment at least 24 hours prior to my appointment. Failure to do so will result in a **$50 cancellation fee.**

SIGNATURE: _____ DATE: _____

WORKERS' COMPENSATION ONLY

You may become responsible for the medical costs of treatment for you illness or condition with the provider listed above 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 occur, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered**. I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment. NY-WCB A9 (1-07)**

SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS ONLY (NOT APPLICABLE FOR DR. ROY DAVIDOVITCH'S PATIENTS)

I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to OrthoManhattan for services furnished to me by OrthoManhattan. I authorize any holder of medical information about me to release to the Center for Medical Services and its agents any information needed to determine these benefits payable for related services.

SIGNATURE: _____ DATE: _____

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

I agree that OrthoManhattan may communicate with me electronically at the email address and/or mobile number provided on my demographic form. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing Orthomanhattan any updates to my email address and/or mobile phone number. I can withdraw my consent to electronic communications at anytime by calling the office.

SIGNATURE: _____ DATE: _____

PATIENT HISTORY FORM

Name:	**Date of Birth:**	**Height:**	**Weight:**

Referred By:	☐ Physician	☐ Self	☐ Family	☐ Friend	☐ Insurance Company	☐ Other

Name of Person/Physician Making Referral:

Reason for Your Visit:	Body Part:	☐Right ☐Left ☐Both
	☐ Acute, New Injury ☐ Old, Chronic Injury	

Approximate date symptoms began, or date of injury? :

Injury Resulted From: ☐ Sports ☐ Accident ☐ Work Related ☐ Other ☐ Unknown

How did your symptoms begin? If sudden, describe onset:

Have you seen another doctor in the last 6 months?

Check all that apply: ☐Pain ☐Stiffness ☐Swelling ☐Instability ☐Weakness ☐Numbness/Tingling

If you have pain, on a scale of 1-10 (10 being most severe), circle # that best describes your pain:	◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

What previous treatment have you had for this problem? (Medications, therapy, surgery, injection, none):

Are you: ☐ **Right Handed** ☐ **Left Handed**	**Occupation:**

PAST SURGICAL HISTORY/AND OR HOSPITALIZATIONS:

Type of operations or reason for hospitalization	Year
1.	
2.	
3.	

Any previous significant injuries or fractures? ☐ No ☐ Yes

Any history of anesthetic complications? ☐ No ☐ Yes

If yes, explain:

MEDICATION INFORMATION:

Drug Allergies: Do you have any drug allergies? ☐ No ☐ Yes

If yes, name the drug and the type of reaction: (rash, trouble breathing, nausea, etc.)

Current Medications: (List all meds including aspirin, vitamins, supplements, calcium, etc.)

Name of Drug	**Dose/Pills per day** (E.g. 500 mg 3 times/day)	**Name of Drug**	**Dose/Pills per day**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

PATIENT HISTORY FORM

Medical History / Review of Systems			
GENERAL	✓	**CARDIOVASCULAR**	✓
Are you currently pregnant?		High cholesterol	
Diabetes		Heart Attack	
Reflux Disease		High Blood Pressure	
Stomach Ulcers		Stroke	
Cancer		Circulatory or Peripheral Vascular Disease	
If yes, What type of cancer?		**MUSCULOSKELETAL**	
Thyroid Problems		Rheumatoid or Inflammatory Arthritis	
Psoriasis		Osteoarthritis	
HIV/AIDS		Osteoporosis	
Hepatitis		Gout	
Tuberculosis		Bone/Joint Infections	
Blood Clots		Fractures or Dislocations	
Seizure Disorders		Stress Fractures	
Concussions		Ligament, Tendon or Joint Injury	
Dental Infections		**PSYCHOLOGICAL**	
Urinary Tract Infections		Depression	
Kidney Stones		Anxiety Disorder	
Prostate Enlargement		Eating Disorders	

Are you currently experiencing any of the following symptoms?

Fever, night sweats or chills		Wheezing		Skin changes, rash	
Unexpected weight loss		Nausea or vomiting		Unsteady gait	
Blurred vision or ringing in ears		Diarrhea or Constipation		Dizziness	
Headaches		Difficult urinating		Tremors	
Difficulty swallowing		Change in bowel habits		Nervousness	
Chest Pain or Palpitations		Blood in urine or stool		Heat / cold intolerance	
Shortness of breath		Swelling of multiple joints		Easy bleeding or bruising	

FAMILY HISTORY

Please indicate which family members (Mother, Father, Sibling, Grandparent) if any have a history of the following conditions:

Diabetes		Abnormal Bleeding Tendencies	
Cancer Type:		Rheumatoid arthritis	
Heart Disease		History of Anesthetic Complications	

Social History

Do you smoke?	No Yes Past	How much do (or did) you smoke?
Do you drink alcohol?	How many drinks per week?	Any history of substance abuse?
List all regular activities you are involved in: (e.g., jogging, basketball, weightlifting, yoga, etc.)		
1.	3.	5.
2.	4.	6.
I, as the patient , state the information is correct and accurate to the best of my knowledge: Signature :		Date:

ROY I. DAVIDOVITCH, MD NEW YORK HIP INSTITUTE T.917.594.4447 F. 646.974.6989 ORTHOMANHATTAN.com

New York State "Surprise Law" April 1, 2015

Patient's Decision

I have reviewed the information provided above and understand that:

- I have the choice of using either a "Health Plan" participating or non-participating health care professional, facility or vendor because there are both types located within this geographic region.
- I understand that if I choose to use a non-participating health care professional, facility, or vendor, such services may not be covered under my plan if my plan does not have out-of-network benefits.
- If my plan has out-of-network benefits, I understand that by using my out-of-network benefits I may incur greater costs for which I will be financially responsible than if I had obtained services from a "Health Plan" participating health care professional, facility or vendor.
- I understand that my provider has opted out of Medicare and will not seek reimbursement from Medicare.

I have made the following decision:

☐ I wish to use my in-network benefits and utilize a "Health Plan" participating health care professional, facility or vendor.

☐ I wish to obtain services from Dr. Roy Davidovitch. I understand he/she is NOT a "Health Plan" participating health care professional, facility or vendor. I also

acknowledge that I have been provided with a copy with this form.

_____ _____

Patient Signature Date

_____

Please print name

I certify that I have reviewed this form with the patient prior to treatment for which the referral is being made and that the patient acknowledged the information contained in this form and was provided a copy for the patient's records:

Sincerely,

Roy I. Davidovitch, MD

ROY I. DAVIDOVITCH, MD NEW YORK HIP INSTITUTE T.917.594.4447 E. ROY.DAVIDOVITCH@NYULANGONE.COM

New York State "Surprise Law"

Fee Disclosure for Out-of-Network Patients

Dr. Roy I. Davidovitch does not participate in the network of your healthcare plan.

The amount that will be billed for the **office visit** is approximately:

$300 for new patients
$200 for follow ups
$100 for Xray
$250 for injections

This amount does not include the amount for other services that may be provided during the office visit. Such services may include radiographic imaging, ultrasound and injections. **If these services are provided, the amount that will be billed for the services may be higher.** The amount of these services can be provided to you at your request.

In addition, fairhealthconsumer.org is an online resource that can help you determine the estimated cost of services. It requires specific codes which can be provided to you upon request.

It is important for you to understand what your health care plan covers if you obtain services from an out-of-network physician.

- Your plan may not cover out-of-network services.
- If your plan covers out-of-network services, your plan may require higher copays, deductibles and coinsurance for out-of-network care.
- The patient acknowledges that Dr. Roy Davidovitch is an out-of network provider but has elected to obtain the services of Dr. Roy Davidovitch. Dr. Davidovitch does not participate with Medicare.

In addition, Dr. Davidovitch may refer you to another physician, physical therapist or other health care provider or facility. Those referrals may or may not be in your health network. Please call to find out if those individuals are a part of your plan before you schedule an appointment.

Acknowledgement of Receipt:

Name: _____

Signature: _____ Date: _____

ROY I. DAVIDOVITCH, MD NEW YORK HIP INSTITUTE T.917.594.4447 F. 646.974.6989 ORTHOMANHATTAN.com

INSURANCE CHECKS SENT TO THE PATIENT

I have been informed by Dr. Roy I. Davidovitch that the checks from my insurance company may be sent directly to me.

These insurance carriers will send checks to the patient:

1. Blue Cross / Blue Shield
2. Oxford Health Plans
3. The Empire Plan (Government Workers)
4. GHI
5. United Health Care
6. Cigna

I AGREE TO GIVE THESE INSURANCE CHECKS TO:

Dr. Roy I. Davidovitch

I understand that these checks from my insurance company are for services provided to me by either:

Roy I. Davidovitch, MD

NYU Langone Medical Center

***Being a group practice, the statement from the insurance carrier may have the name of a different doctor other than your main doctor.**

I AGREE AND ACKNOWLEDGE NOT TO CASH OR DEPOSIT THESE CHECKS.

****IN THE EVENT I FALSELY WITHOLD SUCH CHECKS I AGREE AND ACKNOWLEDGE THAT I AM ULTIMATLY RESPONSIBLE FOR THE AMOUNT OF THESE CHECKS DUE TO DR. ROY I. DAVIDOVITCH.**

If I get insurance checks for services provided by Dr. Roy I. Davidovitch, I agree to forward them to Dr. Roy I. Davidovitch.

Print Name _____ Sign Name _____

Date _____