Long Island Bone & Joint, L.L.P (Medicare) **Date:** _____

Patient Registration and Update Form

Patient Information:

Account #:_____

Name: _____
Social Security Number: _____

Street Address: _____
Mailing Address: _____
City: _____
State: _____ Zip: _____ - _____

Did you go to the emergency room? YES / NO
If yes, which hospital? _____
Date of Visit: _____

Referring Physician: _____
City: _____
Phone Number: _____

Primary Care Physician: _____
City: _____
Phone Number: _____

Emergency Contact: _____
Phone Number: _____
Relationship to Patient:

Home Phone Number: _____
Work Phone Number: _____
Cell Phone Number: _____

Sex: MALE FEMALE
Date of Birth: _____ Age: _____

Email Address: _____

Marital Status: _____

Employment Status:
Full Time Part Time Unemployed Retired

Employers Name: _____
Phone Number: _____
Occupation: _____

Student**:** Full Time Part Time Not a Student
Where: _____
Expected Graduation: _____

Primary Insurance Policyholder's Information:

Policyholder's Name: _____
Address: _____
City: _____
State: _____ Zip: _____ - _____

Home Phone Number: _____
Work Phone Number: _____
Cell Phone Number: _____

Date of Birth: _____ Age: _____
Social Security Number: _____
Sex: MALE FEMALE

Employer: _____
Address: _____
_____
Phone Number: _____
Relationship to Patient: _____

Primary Insurance Information:

Primary Insurance: _____
Address: _____
Phone Number: _____
Effective Date: _____ Expiration: _____
ID Number: _____
Group Number: _____
Copay: _____

Secondary Insurance Policyholder's Information:

Policyholder's Name: _____
Address: _____
City: _____
State: _____ Zip: _____ - _____

Home Phone Number: _____
Work Phone Number: _____
Cell Phone Number: _____

Date of Birth: _____ Age: _____
Social Security Number: _____
Sex: MALE FEMALE

Employer: _____
Address: _____
_____
Phone Number: _____
Relationship to Patient: _____

Secondary Insurance Information:

Secondary Insurance: _____
Address: _____
Phone Number: _____
Effective Date: _____ Expiration: _____
ID Number: _____
Group Number: _____
Copay: _____

Medical History

Please check off any that apply and explain.

Allergies:
- ☐ Drug: _____
- ☐ Food: _____
- ☐ Metal: _____
- ☐ Other: _____
- ☐ NONE

Blood Disease:
- ☐ AIDS / HIV
- ☐ Blood Clot
- ☐ Easy Bruising
- ☐ Blood Disorders: _____
- ☐ Transfusion History: _____
- ☐ Transfusion Reaction: _____
- ☐ Hepatitis: _____
- ☐ Other: _____
- ☐ NONE

Cancer:
- ☐ Specify: _____
- ☐ Cancer Surgery: _____
- ☐ Chemo (when): _____
- ☐ Radiation (when): _____
- ☐ Other: _____
- ☐ NONE

Gastro- Intestinal:
- ☐ Constipation
- ☐ Diabetes Mellitus. Type: _____
- ☐ Diarrhea
- ☐ Hepatitis
- ☐ Hiatial Hernia
- ☐ Liver Disease
- ☐ Nausea
- ☐ Stomachache associated with NSAID's
- ☐ Ulcer
- ☐ Other: _____
- ☐ NONE

Heart:
- ☐ Angina
- ☐ Artificial Heart Valves
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Arrhythmia
- ☐ Heart Attack (year) _____
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stents (what year): _____
- ☐ Pacemaker: _____
- ☐ Anticoagulant use: _____
- ☐ NONE

Nervous:
- ☐ Headaches
- ☐ Anxiety: _____
- ☐ Psychiatric Care: _____
- ☐ Seizure
- ☐ NONE

Diet: Do you have a special diet?
- ☐ No
- ☐ Yes: _____

Infection:
- ☐ Dental ☐ Lyme ☐ Urinary
- ☐ Bone ☐ Joint ☐ NONE
- ☐ Other _____

Respiratory:
- ☐ SLEEP APNEA
- ☐ COPD: _____
- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Other: _____
- ☐ NONE

Musculoskeletal:
- ☐ Artificial Joint: _____
- ☐ Degenerative Joint Disease: _____
- ☐ Cervical Strain
- ☐ Herniated Disc
- ☐ Gout
- ☐ Joint Problems: _____
- ☐ Lumbosacral Strain
- ☐ Old Fracture
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Psoriatic Arthritis
- ☐ Tendonitis
- ☐ Nerve Compression
- ☐ Arthritis
- ☐ Other: _____
- ☐ NONE

Vascular Disease:
- ☐ Arteriosclerosis
- ☐ Edema
- ☐ Stroke
- ☐ Anticoagulation use: _____
- ☐ Deep Vein Thrombosis: _____
- ☐ Other: _____
- ☐ NONE

Other:
- ☐ Kidney Disease
- ☐ Neck / Back Pain
- ☐ Thyroid Disease
- ☐ Other not listed above: _____

Habits:
- ☐ Smoking (Past / Present/ Never)
- ☐ Drug Abuse (Past / Present)
- ☐ Alcohol Abuse (Past / Present)
- ☐ NONE

Family History
- ☐ Anesthetic Complications. Relationship: _____
- ☐ Arthritis. Relationship: _____
- ☐ Cancer. Relationship: _____
- ☐ Deep Vein Thrombosis. Relationship: _____
- ☐ Degenerative Joint Disease. Relationship: _____
- ☐ Diabetes. Relationship: _____
- ☐ High Blood Pressure. Relationship: _____
- ☐ Postmenopausal Osteoporosis. Relationship: _____
- ☐ Rheumatoid Arthritis. Relationship: _____
- ☐ Other: _____
- ☐ NONE: _____

Please note: Primary language is required. If you choose not to answer Race or Ethnicity, please check "Unreported/Refuse to Report"

Primary Language: _____

Race: □ Asian □ American Indian or Alaska Native □ African American □ Native Hawaiian □ White
□ Other Pacific Islander □ More than One Race □ Unreported/Refuse to Report

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unreported/Refuse to Report

Demographics

1. Are you currently taking **any** medications? If so, please list.
   - ☐ Yes → Type: _____
   - ☐ No
2. Pharmacy Name: _____ Phone Number: _____ Address: _____
3. Estimated Height: _____ Estimated Weight: _____
4. Which is your dominant hand? □ Right □ Left □ Both
5. Are you pregnant? □ Yes □ No
6. Are you nursing? □ Yes □ No

Surgical History

1. Have you had any previous surgeries? (If yes, please list year and type)
   - ☐ Yes
   - ☐ No
     - Year: _____ Type: _____
     - Year: _____ Type: _____
     - Year: _____ Type: _____

Reason for Visit

(Please answer the following questions and explain.)

1. Describe your orthopedic complaint: □ Right □ Left □ Bilateral
   _____
   _____
2. When did this problem start (date of injury)? _____
3. How did this problem start?
   - ☐ School
   - ☐ Work
   - ☐ Car accident or an injury that happened inside of your car
   - ☐ Motorcycle/ ATV
   - ☐ Home
   - ☐ Someone else's house
   - ☐ No known injury
   - ☐ Other: _____
4. Have you had any of the following pertaining to this injury?
   □ X-Ray □ MRI □ CT Scan □ NCS/ EMG □ Other: _____ □ None
5. Have you tried physical therapy for this injury?
   - ☐ Yes → For how long? _____
   - ☐ No
6. Have you taken any medications for this complaint previously, or are you currently? If so, what are you taking?
   - ☐ Yes → Please list: _____
   - ☐ No
7. Are you under the care of any other physicians?
   - ☐ Yes → For what? _____
   - ☐ No

Long Island Bone & Joint, L.L.P. Financial Arrangements and Insurance

Patient Name: _____ **Date of Birth**: _____

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding our payment policy.

FULL PAYMENT FOR OUR SERVICES IS DUE AT THE TIME SERVICES IS RENDERED, unless you are a member of an HMO/insurance plan that we participate in. We accept cash, checks, MasterCard, Visa, American Express, or Discover. We request that you provide us with complete insurance information at the time of your initial visit. For fracture care and/or surgical procedures we may accept assignment of insurance benefits. Currently we participate (accept assignment) in:

AARP
BlueCross BlueShield Mather Employee
BlueCross BlueShield Other (Dr. Legouri, Physical Therapy and Dr. Densen only)
Cigna PPO, EPO, Indemnity
Health Republic
Island Group
Magnacare (excluding Oscar)
Medicare
No Fault
Oxford Freedom (Liberty effective 4/1/15)
United Healthcare Choice Plus
Workers'Compensation

If your plan is not listed above please speak with the office to verify participation. If the physician is out-of-network we will provide an estimate of cost upon request. Provider Participation may vary from one provider to the other.

"Accept Assignment" still requires you to pay the required co-payments, co-insurance and deductibles applicable to your particular insurance plan. Return checks are subject to a $20.00 fee. Account balances over 90 days past due, will incur an account management fee of $10.00. Account balances over 90 days past due may be reported to credit reporting agencies as delinquent. The guarantor will be responsible for all collection agency and legal fees associated with balances over 90 days past due. Co-payments not paid at the time pf the visit are subject to $15.00 surcharge.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance. We are not a party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of "U.C.R." "U.C.R." is defined as usual, customary and reasonable fees for this region. Our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. All Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or Managed care **co-pays** must be paid at the time of each visit. Co-payments not paid at the time of the visit are subject to $15.00 surcharge.
5. If you belong to an HMO and you do not have a valid **referral** from your PCP on file or with you, you are required to pay in full for the services rendered at the time of service.

We must emphasize that as a medical care providers, our relationship is with you, not with the insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, call our billing department for help in managing your account. If you have any questions about the above information, PLEASE do no hesitate to ask. We are here to help!

If it is necessary to cancel your scheduled appointment we require 24 hours notice. If you fail to do so, you will incur a **$25.00 No Show/Late Cancellation Charge**.

The information given is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits which I am entitled. **I will not hold Long Island Bone & Joint, L.L.P. or any member of the staff responsible for any errors or omissions that I may have made in completion of this form.** I do hereby authorize the responsible insurance carrier(s) to make payment directly to Long Island Bone & Joint, L.L.P. I understand that I am financially responsible to Long Island Bone & Joint, L.L.P. for charges not paid by my insurance company including Physical Therapy services. I authorize Long Island Bone & Joint, L.L.P. to release any information required to support all claims including Physical Therapy services. I hereby authorize Dr. Fracchia; Dr. Legouri; Dr. McGinley; Dr. Savino; Dr. Yu, Dr. Hubbell; Dr. Marano; Dr. Rana; Dr. Densen and/or their associates or assistants to perform diagnostic and therapeutic measures on the above patient.

Print Name: _____ **Sign**: _____ **Relationship**: _____ **Date**: _____

Payments for today's services will be made by: CASH CHECK VISA MASTERCARD AMEX DISCOVER

HIPAA Notice

- Do we have permission to leave a message (with anything more than an appointment reminder) on your answering machine at home? **YES / NO**
- Do we have permission to leave a message at your place of employment? **YES / NO**
- Do we have permission to discuss your medical condition with any member of your household? **YES / NO**
  If yes, whom: _____ Relationship: _____
  This does not give authorization for anyone to receive your medical records or films. Patients must sign a records release in order to receive copies of those records.
  Please sign this form to acknowledge that you have received and read a copy of our privacy policy. If you have any questions regarding the privacy policy, please ask the physician or one of his staff members.

Print Name: _____ **Sign**: _____ **Relationship**: _____ **Date**: _____

LONG ISLAND BONE & JOINT, L.L.P.

Port Jefferson Office
635 Belle Terre Road
Port Jefferson, NY 11777
Tel: 631-474-0008
Fax: 631-474-0224
(Main Office)

Southampton Office
686 County Road 39A
Southampton, NY 11968
Tel: 631-283-0355
Fax: 631-283-2084

Riverhead Office
788 Harrison Ave
Riverhead, NY 11901
Tel: 631-591-3801
Fax: 631-474-0224

Michael J. Fracchia, M.D. Richard A. Legouri, M.D. Brian J. McGinley, M.D. Richard M. Savino, M.D. John Yu, M.D.
John D. Hubbell, M.D. Henry Marano, M.D., Rasel M Rana, D.O., Stephen R Densen, D.P.M.
Charles J. Ferrer, RPA-C, Michael Suzzi Valli, RPA-C, RPA-C, Kerri Arm, RPA-C, Kenneth Nissen, NP

MEDICARE

Name of Beneficiary (Patient): _____

Address of Patient: _____

Health Insurance Number: _____

I request that the payment of authorized Medicare benefits be made to me or on my behalf to Long Island Bone & Joint, L.L.P., for any services furnished to me by Dr. Michael Fracchia, Dr. Richard Legouri, Dr. Brian McGinley, Dr. Richard Savino, Dr. Yu, Dr. John Hubbell, Dr. Henry Marano, Dr. Rana or Dr. Densen or physician's assistants Michael Suzzi Valli, Charles Ferrer, Kenneth Nissen NP or Kerri Arm. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agent any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

SUPPLEMENTAL/ MEDIGAP (SECONDARY INSURANCE)

Health Insurance: _____

Insurance Number: _____

I request that the payment of authorized Medicare benefits be made to me or on my behalf to Long Island Bone & Joint, L.L.P., for any services furnished to me by Dr. Michael Fracchia, Dr. Richard Legouri, Dr. Brian McGinley, Dr. Richard Savino, Dr. Yu, Dr. John Hubbell, Dr. Henry Marano, Dr. Rana or Dr. Densen or physician's assistants Michael Suzzi Valli, Charles Ferrer, Kenneth Nissen NP or Kerri Arm. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agent any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____