Mount Sinai

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Chief of Spine Trauma, Elmhurst Hospital

Leni & Peter W. May
Department of Orthopaedic Surgery

The Mount Sinai Medical Center
One Gustave L. Levy Place, Box 1188
New York, NY 10029-6574
Tel: [redacted]
Fax: [redacted]

Name: Date: DOB:

Referring Physician: Primary Care Physician:

Location of pain (circle all that apply):

Neck Pain Upper Extremity Pain Mid Back Pain Low Back Pain Lower Extremity Pain

Dominant Hand (circle one): Right Left

Review of Systems [Please check all items you feel are applicable to you]:

__ Recent Infection	__ Fever or chills	__ Weight Loss	__ Difficulty Hearing
__ Arm numbness	__ Leg numbness	__ Genital numbness	__ Cough
__ Bowel incontinence	__ Change in appetite	__ Bladder incontinence	__ Shortness of breath
__ Fatigue	__ Headaches	__ Poor Sleep	__ Muscle weakness
__ Swollen glands	__ Sore throat	__ Eye pain	__ Severe nighttime pain
__ Sinusitis	__ Cold hands/feet	__ Hoarse voice	__ Cough blood
__ Anemia	__ Bronchitis	__ Leg swelling	__ Loss of vision
__ Pneumonia	__ Palpitations	__ Asthma	__ Ringing in ears
__ Murmur	__ Double vision	__ Chest pain	__ Sputum
__ Ulcer	__ Indigestion	__ Blood in stool	__ Limited motion
__ Constipation	__ Pain on urination	__ Blood in urine	__ Muscle aches
__ Difficult urination	__ Kidney stones	__ Swollen joints	__ Thyroid problem
__ Kidney infection	__ Red joints	__ Gout	__ Painful intercourse
__ Arthritis	__ Dry mouth	__ Jitteriness	__ Rash
__ Dry eyes	__ Cold intolerance	__ Vulvar pain	__ Nausea
__ Excess sweating	__ Painful periods	__ Prostate enlargement	__ Abdominal pain

- ☐ Dr. Cho
- ☐ Dr. Colvin
- ☐ Dr. Flatow
- ☐ Dr. Forsh
- ☐ Dr. Gladstone
- ☐ Dr. Hausman
- ☐ Dr. Hecht
- ☐ Dr. Lichtblau
- ☐ Dr. Markinson
- ☐ Dr. Parsons
- ☐ Dr. Qureshi
- ☐ Dr. Weinfeld
- ☐ Dr. Wittig

New Patient Registration Form

Department of Orthopaedics
Mount Sinai School of Medicine

Patient Information

W/C NF Legal

Last Name: _____

First Name: _____

Middle Initial _____

Social Security Number: _____

Date of Birth: _____/_____/_____

Age: _____

Sex: Male Female

Marital Status: _____

Address: _____ Apt. #_____

City, State, and Zip: _____

Home Telephone: _____

Cell: _____

E-mail Address: _____

Employer Name: _____

Employer Address: _____

City, State, Zip: _____

Employer Telephone: _____

Student/Employment Status: _____

Occupation: _____

Guarantor Information

Rel to Guarantor: _____

Guarantor Name: _____

Guarantor SSN: _____

Guarantor DOB: _____

Guarantor Address: _____

Guarantor Telephone: _____

Guarantor Employer's Name: _____

Guarantor Employer's Address: _____

Guarantor Employer's Telephone: _____

Emergency Contact Information

Emergency Contact: _____

Relationship: _____

Telephone Number: _____

Additional Patient Information

Condition that brings you here: _____ Date of Onset: _____

If accident, where and how did it occur? _____

Were you referred by a physician? YES_____ NO_____

If yes, name of physician requesting this consultation: _____

Address of Physician: _____ Phone: _____

Insurance Information

	Primary	Secondary
Insurance Co. Name:		
Insurance Co. Address:		
Insurance Co. Telephone:		
Policy Number:		
Group Number:		
Name of Insured:		
Insured's Date of Birth:		
Relationship of Insured:		
Effective Date:		
Expiration Date:		

PERMANENT INSURANCE SIGNATURE

I request that payment of authorized Medical Benefits be made either to me or on my behalf to the Department of Orthopaedics – Faculty Practice Associates for any service furnished to me by my physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Photostat of this authorization shall be considered as effective and valid as the original.

I acknowledge that I am financially responsible for charges not covered by my insurance carrier due to the physician's non-participating/ out-of-network status with my insurance carrier and /or due to a lack of referral or prior authorization required for today's services should one not be present at the time of service. I acknowledge that I am financially responsible for any deductible, coinsurance, and/or co-payment deemed my responsibility by my insurance carrier as well as any non-covered charges.

Print Patient's Name

Patient's (Or Guardian's) Signature **Date**

❒ Dr. Allen
❒ Dr. Cho
❒ Dr. Colvin
❒ Dr Flatow
❒ Dr. Forsh
❒ Dr. Gladstone
❒ Dr. Hausman

New Patient Registration Form
Department of Orthopaedics
Mount Sinai School of Medicine
5 East 98th Street, 9th Floor

❒ Dr. Hecht
❒ Dr. Iofin
❒ Dr. Lichtblau
❒ Dr. Parsons
❒ Dr. Qureshi
❒ Dr. Weinfeld
❒ Dr. Wittig

Additional Patient Information

Condition that brings you here: _____ Date of Onset: _____

If accident, where and how did it occur: _____

Did a physician refer you? Yes _____ No _____

If yes, name of physician requesting this consultation: _____

Address of referring Physician: _____

Telephone Number : _____

Permanent Insurance Signature

I request that payment of authorized Medical Benefits be made either to me or on my behalf to the Department of Orthopaedics – Faculty Practice Associates for any service furnished to me by my physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Photostat of this authorization shall be considered as effective and valid as the original.

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_____

Print Patient's Name

_____ _____

Patient's (Or Guardian's) Signature **Date**

Mount Sinai

MOUNT SINAI SCHOOL OF MEDICINE

Mount Sinai The Mount Sinai Hospital of Queens
A Division of The Mount Sinai Hospital

Mount Sinai North Shore Medical Group

Mount Sinai Diagnostic and Treatment Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information

_____
Patient Name

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ *The patient refused to sign despite good faith efforts*
- ☐ *The patient was unaccompanied and not alert and oriented*
- ☐ *The patient was unaccompanied and needed emergency care*
- ☐ *Other,(explain):* _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

- ☐ Acknowledgement subsequently obtained, (see above).

MR-205 (Rev 5/04))

Mount Sinai

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A Division of The Mount Sinai Hospital

Mount Sinai North Shore Medical Group

MOUNT SINAI SCHOOL OF MEDICINE

CONSENT FOR COMMUNICATION VIA E-MAIL (Provider-Patient)

I, _____, hereby consent to have my physician, _____, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Signature: _____ Date: _____

E-Mail: _____

MR-240 (9/03) (Orthopaedics)

Mount Sinai

MSSM
MOUNT SINAI SCHOOL OF MEDICINE

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Mount Sinai Diagnostic and Treatment Center

MOUNT SINAI USE OF INFORMATION AUTHORIZATION

Dear Patient,

Like other major academic medical centers, Mount Sinai depends greatly upon the generosity of our patients to help us provide the finest in patient care, educate the next generation of physicians, and promote research and discovery of new treatments and cures.

Federal law now requires hospitals to obtain your written authorization prior to informing you of marketing or philanthropic initiatives that support the work of your doctors. Your authorization below permits Mount Sinai doctors, development officers, trustees, and other staff to learn the name(s) of your health care provider(s) for the purpose of contacting you about marketing or philanthropic efforts that may be of interest to you.

No other information about you or your medical treatment will be disclosed – that is strictly between you and your doctor. Maintaining patient confidentiality and ensuring your right to privacy has always been, and will always be, a priority at Mount Sinai.

We hope you will take a moment to read this authorization and sign below. If you have any questions, please call the Compliance Officer in the Mount Sinai Development Office at (212) 659-1570.

Thank you.

I authorize that the Mount Sinai Hospital and Mount Sinai School of Medicine ("Mount Sinai") may disclose the name of my health care provider(s) to Mount Sinai development officers, and other staff, volunteers, and consultants and contractors assisting in fund-raising efforts, for the purpose of contacting me about Mount Sinai:

☐ *Marketing* ☐ *Fund-raising*

opportunities. I understand that this authorization will expire five (5) years from the date of my signature below. I also understand that my health care treatment at Mount Sinai will not be affected in any way by my refusal or failure to sign this form. I further understand that this authorized information will not be released to any third party vendors for any purpose other than that expressed above. I may revoke this authorization at any time by writing to the Mount Sinai Development Office, One Gustave L. Levy Place, Box 1049, New York, New York 10029-6574. By signing below, I acknowledge that I have read and accept all of the above.

X_____ X_____ X_____

Signature of Patient or Personal Representative/Guardian

Print Name of Patient or Personal Representative/Guardian

Date

X_____

Address *of Patient*

_____

If Applicable, Description of Authority of Personal Representative/Guardian

The patient or personal representative/guardian may request a copy of this form.

MR-212 (REV 4/06)

OFFICE USE ONLY _____

Leni & Peter W. May
Department of Orthopaedics

The Mount Sinai Hospital
One Gustave L. Levy Place, Box 1188
New York, NY 10029-6574
Tel.: (212) 241-6144

Global Fracture Care

Dear Mr./Ms._____

You insurance company requires that we report our services to them using a coding system known as CPT (Current Procedural Terminology). The CPT codes used to describe the services we did for you are found in the "Surgery" section of the CPT workbook. This does not mean we are implying that you had an operation. This is merely the way the CPT book is organized for ease of use by both insurance companies and physicians.

According to CPT guidelines, fracture care may be reported to the insurance company as a "packaged" service. This means that at the time of initial care, a claim is generated that includes the following work/service:

1. The application of the first cast or splint
2. 90 days of normal, uncomplicated, follow-up care

The services that are not included in the fee associated with the fracture are billed separately:

1. X-rays (initial and all follow-up)
2. All casting supplies (including those used in the first cast or splints)
3. Replacement cast application for medical necessity
4. Evaluation and management of any additional problems or injuries
5. Treatment of complications, return to operating room

There will be a separate charge for these and any appropriate copayments, deductibles, or coinsurances may apply.

Note: Cast replacements that are not for medical necessity may be denied by your insurance company and may be billed to you, the patient or guarantor of service.

If you have any questions, please do not hesitate to contact the billing office at 212-241-6980.