Chart:

SpineCare of New York

FRANK P. CAMMISA, JR., M.D.
ANDREW A. SAMA, M.D.
ALEX P. HUGHES, M.D.
EAST RIVER PROFESSIONAL BUILDING
523 EAST 72ND STREET, 3rd Floor
NEW YORK, NY 10021

PATIENT INFORMATION

Today's Date:_____ Appt Date:_____ Chart # _____

Name: _____ Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell: _____

Home Telephone: _____ Business Telephone: _____

Employer: _____ Address: _____

Age: _____ Date of Birth: _____ Social Security No.: _____

Occupation: _____ Date Disability Began: _____

Work Status: Regular _____ Light Work _____ Totally Disabled _____

Marital Status: M S W D Gender M/F_____ Gender Identity_____

Referring Physician (**address and telephone**): _____
Have you seen this MD? yes no

Name AND address of physicians who will need copies of your medical report:
Without correct addresses, the report will be returned to you for processing.

_____

If Minor - Names of Parents:_____

Person to Contact in and Emergency (include phone and relationship):

_____

Compensation Case? _____ Auto Accident? _____ Registration State _____

Comp or Auto Insurance Carrier (Address and Telephone): _____

_____

DO NOT MAIL THIS FORM, E-mail to Spineid@hss.edu or Fax to 646-360-5020

Pharmacy Information:
Name: _____
Address: _____
Phone: _____

You must bring all imaging (CD's/Films) to your appointment or your appointment will need to be rescheduled

Chart:

WCB/NF POLICY HOLDER: _____ POLICY NO: _____
CARRIER CASE NUMBER: _____ WCB NUMBER: _____

HOSPITAL AND MAJOR MEDICAL INSURANCE

MAJOR MEDICAL COMPANY (doctor's coverage) (address, policy/group number): _____

_____

HOSPITAL INSURANCE (address, policy/group number): _____

_____

__ I have not hospitalization insurance / I have no major medical

DATE OF INJURY / ONSET OF SYMPTOMS: _____ Lawsuit Pending*: yes no

*Should any litigation arise, it is understood and agreed that the treating physician will not participate in any way in litigation except to provide true and accurate copies of any medical records in possession.

X _____ Signature of Patient

Credit Card Authorization- I authorize, when requested by me **over the phone**, use of my credit card for outstanding charges.

Fee for the initial consultation is: $750.00 (850.00 as of 3/1/24) This fee does not apply to patients who are covered by Medicare, Workmen's Compensation, No Fault and participating managed care plans. This charge is for the doctor's consultation only. It does not include X-Rays or other services which may be rendered. We do not accept assignment of insurance. This fee is payable ON THE DAY OF YOUR VISIT. **Note:** Telemed (audio-visuals and extended phone calls are billable)

Delinquent payment fee, collection cost and attorneys fee:

It is understood that the patient or other responsible party shall pay Dr. Cammisa / Dr. Sama / Dr. Hughes within thirty days after receipt of a bill from Dr. Cammisa / Dr. Sama / Dr. Hughes stating that the balance is due. In the event that full payment is not made within thirty-five days of the mailing of said bill, unless agreed in writing to the contrary, the patient or other responsible party will be charged an interest rate of 9% per annum on all accounts not paid in full by the due date. If the delinquent balance is not paid in a timely manner after the final due date, and the doctor employs a collection agency or attorney, you will be required to pay collection fees and other related costs, including reasonable attorneys' fees, in addition to your balance due, plus interest as aforesaid.

Relevant state laws shall govern this understanding. Further, you agree that in any action to collect payment hereunder, you hereby waive your right to trial by jury and the right to interpose counterclaims in any action brought for enforcement of the agreement. You may bring separate action for any disputes you may have with the doctor related to the contract or otherwise.

Please note that during the course of your treatment, there will be occasionally be the need for conferences with other doctors, phone consultations with and regarding you, and the like. For this purpose we retain your signature on file authorizing us to bill your insurance carrier for these efforts. You are NOT billed directly for additional consulting services performed out of the context of your visit to us. **Please bring insurance forms, completed and signed, with you for this purpose.**

I request that payment of authorized **MEDICARE** benefits and all insurances be made either to me or on my behalf to Dr. Cammisa / Dr. Sama / Dr. Hughes for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for **MEDICARE** and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize insurance payments be made directly to Dr. Cammisa / Dr. Sama / Dr. Hughes

Policy Holder's Name: _____ Date: _____

Policy Holder's Signature _____ Date: _____

Guarantor Signature: _____ Date: _____

Chart:

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NEW YORK, NY 10021
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Telephone: 212/606-1946

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also agree that **SpineCare of New York** may request to use my prescription medication history from other healthcare providers or 3rd party pharmacy benefit payors for treatment purposes. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Patient Name: _____ Social Security: (last 4 digits only) _____

Persons/Organizations authorized to use, disclose, or receive my information:

_____
_____
_____

Specific description of the information to be used and disclosed (including date(s)):

_____
_____

Description of each purpose regarding the use or disclosure of my health information:

At the request of the patient.

I understand that this authorization will expire on: _____ Initials _____

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form, Initials _____

I understand that I will get a copy of this form after I sign it. Initials _____

I understand that I may revoke this authorization at any time by notifying the Practice in writing, but if I do, the revocation will not have any effect on the actions the Practice has already taken in reliance on this authorization. Initials _____

I understand that telehealth involves sharing my health information electronically. I will tell my healthcare provider if there is any information that I do not want to talk about in a telehealth visit Initials _____

I understand that telehealth involves sharing my health information electronically. I will tell my healthcare provider if there is any information that I do not want to talk about in a telehealth visit Initials _____

_____ _____
Signature of patient Date

If this authorization is signed by a patient's representative, please complete the following:

_____
Printed name of patient's representative

_____
Relationship to the patient

Name:
Chart:
Date:

Name: _____ Date: _____

Age: _____

Please check one: ☐ Left hand dominant ☐ Right hand dominant ☐ Ambidextrous

Accompanied by: ☐ Myself ☐ With (list name & relation to patient):_____

List your primary symptoms in order of importance:
(ie low back pain, neck pain, arm/leg pain, arm/leg weakness, sensation changes, imbalance, etc)

1. _____
2. _____
3. _____

Please check if you have any of the following symptoms (if applicable, list body part affected):

☐ Weakness:_____

☐ Numbness:_____

☐ Pins & Needles: _____

☐ Balance Impairment ☐ Gait disturbance ☐ Postural Changes

☐ Bowel Dysfunction ☐ Bladder Dysfunction

How and ***When*** did your symptoms start? (Please describe any trauma/injury, motor vehicle accident, gradual, etc)

_____

_____

List name and specialty of other physicians seen for your symptoms (surgeons, neurologists, etc—ie Dr. Jon Doe-pain management):

_____

_____

_____

Any history of spine problems prior to current issue? ☐ Yes ☐ No
If Yes, ☐ Lumbar ☐ Cervical ☐ Thoracic

Any history of previous spinal surgery? ☐ Yes ☐ No

If Yes, please include: date, type of surgery, and name of surgeon

_____

_____

_____

Name:
Chart:
Date:

Which treatments have you tried? (Please include number of sessions and/or dates of treatment)

- ☐ Epidural Steroid Injections: _____
- ☐ Facet Injections: _____
- ☐ Trigger Point Injections: _____
- ☐ Physical Therapy: _____
- ☐ Chiropractic Care: _____
- ☐ Acupuncture: _____
- ☐ Oral Steroids (i.e. Prednisone, Medrol 6-day pack): _____
- ☐ Other Treatments: _____

If you have pain, please complete the following three questions:

1. Please rate your current pain on a scale of 0-10, with 0 being no pain and 10 being severe:

_____ Back	_____ Right buttock/leg	_____ Left buttock/leg
_____ Neck	_____ Right arm	_____ Left arm

2. What makes your symptoms worse?

_____

3. What makes your symptoms better?

_____

Do your symptoms affect your ability to fall or stay asleep? ☐ Yes ☐ No

Are symptoms worse at a particular time of day?

☐ Upon rising in the morning ☐ At the end of the day ☐ During the night

Is your condition:

☐ Getting worse over time ☐ Getting better since initial onset ☐ The same over time

Name:
Chart:
Date:

PAST MEDICAL HISTORY

Are you currently having or have you had any of the following conditions (check all that apply):

☐ Heart Attack/Heart Failure	☐ Sleep Apnea	☐ Fibromyalgia
☐ Heart Murmur/Irregular Heart Beat	☐ Acid Reflux/GERD	☐ Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)
☐ Peripheral Vascular Disease	☐ Stomach/Intestinal Disease	☐ Glaucoma/Cataracts
☐ Anemia	☐ Hepatitis/Liver Disease	☐ Migraines/Headaches
☐ Clotting/Bleeding Disorder	☐ Kidney Problems	☐ Pneumonia
☐ High Blood Pressure	☐ Urinary Problems	☐ Tuberculosis
☐ High Cholesterol	☐ Diabetes	☐ HIV/AIDS
☐ Seizure	☐ Thyroid/Parathyroid Issues	☐ Anxiety/Depression
☐ Stroke/TIA	☐ Osteoporosis/Osteopenia	☐ Substance Abuse (ie opioid)
☐ Asthma	☐ Autoimmune Disease	☐ Surgical Complications or Infections
☐ COPD/Emphysema	☐ Gout	☐ Cancer

☐ Other: _____

CURRENT MEDICATIONS (include prescription drugs, over-the-counter medications, vitamins, and supplements)

Medication:	Dose	Frequency:	Reason for Taking:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(If more medications, please attach separate medication list)

Have you been taking opioids for 3 months or more? ☐ Yes ☐ No

Name:
Chart:
Date:

PREVIOUS SURGERIES (include dates)

_____

_____

_____

MEDICATION ALLERGIES (list medication and reaction)

_____

_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____

Recreational Activities/Hobbies: _____

Smoking Status: ☐ Never Smoked ☐ Current Smoker ☐ Former Smoker

If current or prior smoking history, how many packs per day? _____

How many years have you smoked in total? _____

If former, quit date: _____

How many alcoholic beverages do you consume a week? _____ If former, quit date: _____
(1 drink = 12 oz beer, 5 oz of wine, 1.5 oz hard liquor)

Recreational drug use? ☐ Yes ☐ No ☐ If yes, list drug(s): _____

FAMILY HISTORY
Do you have a family history of any of the following conditions?

	Yes	No	Type of Condition:	Family Member:
Spinal Disorders	☐	☐		
Muscle/Nerve Disorders	☐	☐		
Autoimmune Disease	☐	☐		
Cancer	☐	☐		
Other	☐	☐		

Name:
Chart:
Date:

THIS PAGE TO BE COMPLETED BY CLINICIAN OR M.D. AT TIME OF VISIT

REVIEW OF SYSTEMS

General _____

Skin _____

Neurological _____

HEENT _____

Cardiovascular _____

Pulmonary _____

Gastrointestinal _____

Urinary _____

Renal _____

Hepatic _____

Other _____

PHYSICAL EXAM VITAL SIGNS:

BP	**HR**	**RR**	**Temp**	**Height**	**Weight**
BMI	**02 SAT**				

Gen:	[ ] well developed/well nourished	[ ] no acute distress
Neuro:	[ ] NC/AT	[ ] PERRL
	[ ] CTA b/l	[ ] No W/R/R
	[ ] RRR	[ ] No M/R/G
Abd:	[ ] NT/ND	[ ] Positive bowel sounds
Ext:	[ ] No edema	[ ] < 2 cap refill
Derm:	[ ] No ulcers/rashes	

Chart:

This page to be completed by M.D. at time of visit.

CHIEF COMPLAINT

Neck

Pain

Loc

Numb

P/N

Weak

B/B Sx

B/Gait

Lher
Spur
Abd

Val

NP

Pos
Walk
Stand
Sit
Sup
Prone
Drive
Sleep
Work
Rec

Back

EXAMINATION **Init:** _____

Date dict: _____

Neck			**Back**	
	Right	*Left*	*Right*	*Left*
	B			K
	T			A
	BR			Clo
	Hof			Bab
	IRR			

Reflexes

Sensation

C5				L2
C6				L3
C7				L4
C8				L5
T1				S1
TR				

Power

D				HF
B				HA d
WE				Q
T				TA
WF				EHL
FE				Hab
GR				Hex
Fab				GS
				Hams

Heel Raise	List	Gower
TW/HW	SLR	FF
Lhermitte's	CLSR	EX
Spurling	Bowstring	Gait
Shoulder	FST	Pulse
Crpl Tnl	Prone	Rectal
Cubt Tnl	Stairs	
Hip		
SNt		

NSAID	TPI	Acupuncture
Analgesics	FI	Brace
OS	PT	Pain Clinic
ESI	Chiropractic	EMG

DX:

RX: Surgical

Conservative:

Tests:

X-Rays	_____
Bonescan	_____
CT	_____
MRI	_____
Myelogram	_____
EMG	_____
Discogram	_____
Other	_____