New York Center for Spinal Disorders

Nathaniel L. Tindel, MD
Neel P. Shah, MD
425 East 79th Street, Suite 1H
New York, NY 10075
(212) 249-3840

Patient Information (Please print CLEARLY and COMPLETELY) **Date** _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ Apt: _____ City: _____ State: ____ Zip: _____

Telephone: _____ (Cell/Home) _____ (Work) Email: _____

Emergency Contact: _____ Relationship: _____ Telephone: _____

Referring Dr: _____ Phone: _____ Are you filing for Worker's Comp or No Fault: **YES / NO**

Primary Dr: _____ Phone: _____ Are you working w/an Attorney: **YES / NO**

History
Gender: _____ Height: _____ Weight: ____(lb) Marital Status: _____ Occupation: _____

Social: Alcohol ____ Drinks/day ____ Socially____ Tobacco: Y/N, if Yes ____ packs/day; Vaping: Y/N;
Other drug use:_____

Medical Information:
Current Problem: _____
How did it occur: _____Duration of symptoms: _____
Recent Imaging/Treatment for current problem: _____
_____
_____

Current & Past Medical Problems:

☐ Heart Problems	☐ Coronary Artery Disease	☐ Irregular Heart Beat	☐ Pacemaker
☐ High Blood Pressure	☐ Diabetes	☐ Lung problem	☐ Asthma
☐ Cancer	☐ Stroke	☐ Prolonged Bleeding	☐ Blood Clots
☐ Neuropathy	☐ Stomach Ulcers	☐ Intestinal Problems	☐ Seizures
☐ Osteoporosis	☐ Thyroid Disease	☐ Rheumatoid Arthritis	☐ Sleep Apnea
☐ Allergy to Latex	☐ Kidney Disease	☐ HIV/AIDS	☐ Hepatits A, B or C

Explain/other problems: _____
_____ Allergies: _____

Current Medications:_____

Past Surgeries (include dates): _____
_____
_____

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

Insurance Information (Please have copy of card available)

Primary Insurance

Company: _____ Claims Address: _____
ID#: _____ Group#: _____
Policy Holders' name: _____ Relationship to Patient: _____
Policy Holders' DOB: _____ Policy Holders' Employer: _____

Secondary Insurance

Company: _____ Claims Address: _____
ID#: _____ Group#: _____
Policy Holders' name: _____ Relationship to Patient: _____
Policy Holders' DOB: _____ Policy Holders' Employer: _____

Worker's Comp or No Fault: Please provide Attorney information and any other insurance information below:
-Please be advised – Dr. Tindel does not participate in Workman's Comp or No fault (only Dr. Shah)

Claims Authorization for All Patients:
I hereby authorize any physician, health care practitioner, hospital, clinic or other medical facility to furnish any and all records pertaining to medical history, services rendered, or treatment given to me or my dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s).

I also authorize my insurance carrier(s) to disclose to a hospital or healthcare service plan, self-insurer or an insurer, any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim of term of coverage with my insurer(s) including reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

Additional Authorization for Medicare Policyholders
I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Assignment of Benefits
I authorize payments of medical and surgical benefits to be made on my behalf to my physician(s) in this office. I also understand I am fully responsible for this bill if the insurance company either denies or neglects the amount due.

Patient/Relative/Guardian Name: _____

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

Non Participating / Out of Network Agreement

I have been notified that my provider(s) at this practice are not in network / participating provider(s) with my insurance.

I understand that because they are not an in-network / participating provider(s) with this insurance company that I will be responsible for all consult payments, including the annual deductibles, co-pays and co-insurance of this and all follow-up & surgery visits included.

Patient/Relative/Guardian Name: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ☐ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- ☐ Obtain payment from third-party payers
- ☐ Conduct normal healthcare operation such as quality assessments and physician certifications

I have received, read and understand your *Notice of Privacy Practices* containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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Patient Name: _____ Date: _____

Important Office Policies and HIPAA Consent Acknowledgement

By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explain special privacy protections that apply to HIV related information, alcohol and substance abuse treatment information, mental health information and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operation of this practice, its physicians and staff.

To ensure confidentiality and privacy, any type of electronic recording including but not limited to audio, video and photo is strictly prohibited at any location within this office. Thank you for understanding and compliance.

In the event of an emergency, immediately call 911 and be taken to the nearest emergency room. Our use of email and any other form of electronic communication is limited to routine matters and it is not regularly monitored and is definitely not intended to be used for emergency or urgent matters.

Print name (Patient or Authorized Agent): _____

Signature (Patient or Authorized Agent): _____ Date: _____

Authorization for Release of Medical Benefits and Payment Agreements

I verify accuracy of the information provided on the Patient Demographic sheet and authorize release of information necessary to process any claims. I also understand that The New York Center for Spinal Disorders may not participate with my insurance and I am therefore responsible for all services. Additionally, I will be responsible for all the balances after insurance payments. I will work with the doctor's office to help facilitate reimbursement from my insurance company and I understand that all bills are my responsibility if not paid by my carrier.

If there are any questions or concerns about billing or the services rendered please notify our office immediately. Because you may receive payments directly from the insurance carrier, you agree to forward those payments to our office promptly along with the explanation of benefits (the paper attached to the check that explains the payment). Upon receiving any payment or explanation of benefits from your carrier regarding services provided, please call our office to advise us of such payments and/or notification. Should you receive a payment from the insurance carrier for serviced provided, the payment(s) is/ are due to be received by The New York Center for Spinal Disorders within 30 business days from the date of the receipt. Should the payment(s) not be received by The New York Center for Spinal Disorders within 30 business days from the date of the check, the insurance payment and any other payments due, including but not limited to the remainder of any outstanding balance will accrue interest at the maximum rate permitted by applicable laws (and, if allowed by applicable law, no less than 1% per month). Should it be necessary to utilize a third party or legal process for the collection of any payment or outstanding amount The New York Center for Spinal Disorders will be entitled to recover the payment in addition to the costs of collection including, but not limited to, professional time expended by attorneys and/or collection agency, court fees, and/or any reasonable expenses, as applicable by law.

Print name (Patient or Authorized Agent): _____

Signature (Patient or Authorized Agent): _____ Date: _____

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Notice of Non-Participation

Please be advised that Dr. Nathaniel Tindel is NOT a participating provider for No-Fault Insurance cases, Workers' Compensation, or Lien Cases.

This means that we are unable to bill these types of claims directly, and payment for services will be the patient's responsibility at the time of service. I understand that because he is not a participating provider, I will be responsible for all consult payments, including any deductibles, copays and co-insurance. This will include the initial visit, any follow-ups and surgeries.

If you have any questions regarding payment options, please speak with our front desk staff before your appointment.

I attest that I have been advised of the above notice.

Patient Name: _____

Signature: _____

Date: _____

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Patient Name: _____ Date: _____

Please indicate your average pain level (circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

Please describe the pain that you are feeling in our own words (Use the diagram below to indicate the location of any pain and radiation of pain)