SHERBAN ORTHOPAEDICS AND SPINE SURGERY, PLLC

2914 Elmwood Avenue, Kenmore NY 14217
55 Spindrift Drive, Williamsville NY 14221
3673 Southwestern Blvd, Orchard Park, NY 14127
PHONE: (716) 447-6310 FAX: (716) 775-6288

GENERAL INFORMATION

PATIENT NAME : _____

ADDRESS : _____

TELEPHONE : HOME : _____ **CELL :** _____

DATE OF BIRTH : _____ **SEX : MALE :** _____ **FEMALE :** _____

SOCIAL SECURITY NUMBER : _____

CHIEF COMPLAINT: _____

No Fault

Understand that without majority of the below information, you or your back-up insurance may be billed in lieu of missing information about your No Fault claim.

The more information we have, the more timely we are able to process any requests for additional testing, surgery, braces, etc that the physician may/may not wish to order at your appointment. If you are unsure how to obtain the below information, before you arrive at our office, contact your Auto Insurance, they will assist you.

AUTO INSURANCE INFO {for the vehicle you were in at the time of the accident}	
Insurance Company:	
Insurance Company Address:	
Name of Policy Holder:	
Relationship to Policy Holder:	
Policy Number:	
NF Claim Number:	
NF Claim Examiner/Adjuster:	
Examiner/Adjuster Phone #:	
Examiner/Adjuster Fax #:	
ACCIDENT INFORMATION	
Date of Accident:	
Type of injury sustained:	
Brief Description of how accident occurred:	
Have you been treated by another doctor for this injury please provide name(s):	

I,_____ authorize my physician/Health Care Solutions of WNY, LLC to release any information pertaining to my auto accident to my insurance (for the duration of my treatment for this incident)

Signature:_____ Date:_____

In the event that the above information is not furnished, the charges will be mailed directly to you.

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GENERAL INFORMATION***

***(You do NOT have to fill out GENERAL INFORMATION portion, if this insurance is secondary to NF/WC)**

PATIENT NAME : _____
ADDRESS : _____
TELEPHONE : HOME : _____CELL : _____
DATE OF BIRTH : _____SEX : MALE :_____FEMALE :_____
SOCIAL SECURITY NUMBER : _____

CHIEF COMPLAINT:_____

EMERGENCY CONTACT INFORMATION

NAME : _____
RELATION : _____
TELEPHONE : HOME : _____CELL : _____

PRIVATE INSURANCE INFORMATION

PRIMARY INSURANCE : _____
ID# :_____GROUP# :_____
SECONDARY INSURANCE : _____
ID# :_____GROUP# :_____

CORRESPONDENCE INFORMATION

REFERRED BY:
Address: _____
Telephone: _____

PRIMARY MEDICAL DOCTOR:
Address: _____
Telephone: _____

ATTORNEY INFORMATION:
Name: _____
Address: _____
Telephone: _____

INSURANCE AUTHORIZATION
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ALSO AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIANS. I AGREE THAT THIS AUTHORIZATION WILL COVER ALL MEDICAL SERVICES RENDERED UNTIL SUCH AUTHORIZATION IS REVOKED BY ME. I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN LIEU OF THE ORIGINAL.
SIGNATURE : _____ DATE : _____

NEW YORK MOTOR VEHICLE INSURANCE FORM
ASSIGNMENT OF BENEFITS

(FOR ACCIDENTS OCCURRING ON OR AFTER 03/01/2002)

I, _____ ("Assignor") hereby assign to **ROSS SHERBAN, D.O**, ("Assignee")
all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby verifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on **_____,** under **Claim Number** _____, with _____ **Insurance Company** notwithstanding any other agreement to the contrary.

This agreement may be revoked by the Assignee when benefits are not payable based upon the Assignor's lack of insurance coverage and/or violation of a policy condition due to actions or conduct of the Assignor and/or a denial of a claim submitted to Assignor's No-Fault Carrier, upheld upon arbitration.

ANY PERSONS WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSONS WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____
(Patient's signature)

_____
(Patient's Name)

_____

_____
(Patient's address)

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AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

NAME OF INSURER:_____

PIP POLICY NUMBER:_____

NAME OF INSURED:_____

DATE OF ACCIDENT:_____

CLAIM NUMBER: _____

I._____ hereby authorize and direct
(Patient Name)

_____
(Insurance Company)

To provide Sherban Orthopaedics and Spine Surgery, PLLC an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date upon request.

_____
(Signature of Patient/ Insured)

_____
(Date Signed)

_____
(Representative of Sherban Orthopaedics and Spine Surgery, PLLC)

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DATE: _____

NAME: _____ OCCUPATION: _____
Last First Middle

EMPLOYMENT STATUS: _____

DATE OF BIRTH: _____ MALE / FEMALE MARITAL STATUS: _____

HEIGHT: _____ WEIGHT: _____ ALLERGIES: _____

MEDICAL HISTORY QUESTIONNAIRE

Family Physician: _____ Attorney: _____

Referring Physician/Chiropractor_____ Physical Therapy: _____

Any Other Specialist(s): _____

PHARMACY: _____

MEDICATIONS: Please list your most current medications and who prescribes them
OR
( ) PLEASE SEE ATTACHED LIST PRESCRIBED BY:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____
9. _____ _____
10. _____ _____

SOCIAL HISTORY: Please do not leave any question blank

ALCOHOL: DO YOU DRINK? Y OR N IF YES, HOW MUCH AND HOW OFTEN:

RARE/SOCIAL _____ OCCASIONAL_____ MODERATE_____

SMOKING AND CHEWING TOBACCO: DO YOU SMOKE? Y OR N IF YES, HOW MUCH AND HOW OFTEN:

< PACK A DAY _____ 1-2 PACKS A DAY _____ >3 PACKS A DAY _____ CHEWING TOBACCO_____

PREVIOUS SMOKER: Y OR N WHEN DID YOU QUIT? _____

EDUCATION: WHAT IS THE HIGHEST LEVEL OF EDUCATION YOU HAVE OBTAINED? _____

Surgical History & The Date Performed:

_____ _____ _____
_____ _____ _____
_____ _____ _____

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DATE: _____

PRESENT MEDICAL CONDITIONS: Please check any medical conditions you are being treated for or have been in the past
NO MEDICAL PROBLEMS REPORTED ☐

MEDICAL PROBLEMS	YOURSELF	FAMILY MEMBERS
Asthma		
Emphysema		
COPD		
Pneumonia		
Tuberculosis		
Pulmonary Embolism		
Respiratory Arrest		
Sleep Apnea		
High Cholesterol/Lipids		
High Blood Pressure		
Stroke / TIA		
Mitral Valve Prolapse		
Congestive Heart Failure		
Angina (Chest Pain)		
Coronary Heart Disease		
Heart Attack (Myocardial Infarction)		
Arrhythmia (Irregular heart beat)		
Inflammatory Bowel (Diverticulitis/losis)		
Acid Reflux (GERD)		
Gastric / Stomach Ulcer		
GI Bleed		
Hepatitis or liver disease		
Kidney problems		
Dialysis or Kidney Failure		
Urinary tract infections		
Diabetes		
Thyroid problems		
Osteomyolitis		
Bleeding disorders		
Anesthesia problem / Malignant hyperthermia		
Peripheral Vascular Disease (PVD)		
Deep Vein Thrombosis (DVT)		
Cerebral Palsy		
Polio		
Parkinson's		
Multiple Sclerosis		
Ulcers skin/pressure		
Psoriasis		
Tooth abscess		
Gingivitis		
Rheumatoid Arthritis		
Gout		
Lupus		
Scleroderma		
Depression		
Anxiety		
Sickle Cell Disease		

Drug or Alcohol Dependency		
HIV / AIDS		
Cancer		

Sherban Orthopaedics and Spine Surgery, PLLC
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35 Batavia City Center, Batavia NY 14020

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Fax: **716-775-6288**

Ross Sherban, D.O.
Fellowship Trained Orthopaedic
Spinal Surgeon

Email: **scheduling@drsherban.com**
Website: **www.drsherban.com**

American Academy of Orthopaedic Surgeons
American Osteopathic Academy of Orthopaedics
North American Spine Society
American Osteopathic Asscociation
American Medical Association
Association of Orthopaedic Surgeons
AOSpine

Narcotic Medication Agreement

I,_____ understand that:

- **I will call the office five (5) business days ahead of my refill date. P# 716-447-6310 EXT 3.**
- **I understand that while obtaining medications from Sherban Orthopaedics and Spine Surgery and/or associates**
- The overuse of narcotic medication can result in serious health risks.
- You should not drive or operate machinery while taking narcotic medications.
- All prescriptions must be filled at one (1) pharmacy only and prescribed by one (1) doctor only, this includes emergency department prescriptions.
- I agree to a random urine drug testing.
- **This medication will be strictly monitored and ALL of the medications will be filled at the SAME pharmacy.**

  The pharmacy I have chosen is: _____

  Phone #: _____ Address:_____
- **Early refill requests will not be honored & I will take my medication ONLY as prescribed.**
- I am responsible for MAKING & KEEPING scheduled appointments. I understand that I will need to be seen approximately EVERY month while I am being prescribed narcotic medications.
- I understand that if I am not able to keep my appointments my medications will not be refilled.
- I WILL NOT obtain narcotic medication from any provider while obtaining medications from Sherban Orthopaedics and Spine Surgery and/or associates. If it is found that other providers are prescribing for me, Dr. Sherban and/or his associates reserve the right to discontinue prescribing medications and/or discharge me.**
- **Your prescription or medications WILL NOT be replaced if they are lost, destroyed, stolen, get wet, misplaced etc. under any circumstances.**
- Notify us immediately if you become pregnant.

I have read the Narcotic Medication Agreement and by signing I affirm that I have read, understand, and accept all of the terms of this agreement.

**PAIN MANAGEMENT PROVIDER:_____

Patient Signature:_____ Date:_____

Witness Signature: _____ Date:_____

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Dr. Ross Sherban
Fellowship Trained Orthopaedic
Spinal Surgeon

Email: **scheduling@drsherban.com**
Website: **www.drsherban.com**

American ademy of Orthopaedic Surgeons
American Osteopathic Academy of Orthopaedics
North American Spine Society
American Osteopathic Asscociation
American Medical Association
Association of Orthopaedic Surgeons
AOSpine

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

The undersigned hereby consents to and authorizes the release of all medical reports, hospital records, and X-ray films concerning my physical condition, past and present by _____ and their employees.

The information to be disclosed shall be limited to the following:

(Please check appropriate box :)

Office Reports ( )
Other (X) Please list: **ALL MEDICALS ON FILE**

This disclosure is made for the following purpose:

(Please check appropriate box :)

Continued Care (X)
Legal ( )
Other ( ) Please specify: _____

I specifically authorize the release of this information to: **Ross Sherban D.O.** and his employees, or any person authorized by him/her to examine any of the aforesaid records. This Authorization is subject to written revocation at any time except to the extent that action has been taken in reliance thereon.

Phone: 716-447-6310 **Fax: 716-775-6288**

This Authorization is limited to the furnishing of the above records only and shall not be construed as authorizing you to communicate orally or in writing concerning my medical condition other than for the purpose of furnishing records.

Signature: _____

Date: _____

LUMBAR SPINE FUNCTIONAL REPORT

PATIENT NAME:_____ DOB:_____

DATE:_____OP DATE:_____

OSWESTRY RATING
CHOOSE **ONE** ANSWER FROM **EVERY** CATEGORY

1.) Pain Intensity:
( ) I have no pain at the moment
( ) The pain is very mild at the moment
( ) The pain is moderate at the moment
( ) The pain is fairly severe at the moment
( ) The pain is very severe at the moment
( ) The pain is the worst imaginable at the moment

2.) **Personal Care**: (*Washing, Dressing, ect.)*
( ) I can look after myself without causing extra pain
( ) I can look after myself normally, but it causes extra pain
( ) It is painful to look after myself and I am slow and careful
( ) I need some help but manage most of my personal care
( ) I need help everyday in most aspects of self care
( ) I do not get dressed, wash with difficulty and stay in bed

3.) Lifting:
( ) I can lift heavy weights without extra pain
( ) I can lift heavy weights but it causes extra pain
( ) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (Ex. On a table.)
( ) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned (Ex. On a table.)
( ) I can only lift very light weights
( ) I cannot left or carry anything at all

4.) Walking:
( ) Pain does not prevent me walking any distance
( ) Pain prevents me from walking more than one (1) mile.
( ) Pain prevents me from walking more than a half (½) a mile.
( ) Pain prevents me from walking more than a quarter (¼) mile.
( ) I can only walk using a cane or crutches.
( ) I am in bed most of the time, I can only walk to the toilet.

5.) Sitting:
( ) I can sit in a chair as long as I like.
( ) I can only sit in my favorite chair as long as I like.
( ) Pain prevents me sitting for more than one (1) hour.
( ) Pain prevents me sitting for more than half (½) an hour.
( ) Pain prevents me sitting for more than ten (10) minutes.
( ) Pain prevents me from sitting at all.

PATIENT NAME:_____ DOB:_____

DATE:_____OP DATE:_____

6.) Standing:
( ) I can stand as long as I want without extra pain.
( ) I can stand as long as I want, but it gives me extra pain.
( ) Pain prevents me standing for more than one (1) hour.
( ) Pain prevents me standing for more than half (½) hour.
( ) Pain prevents me standing for more than ten (10) minutes.
( ) Pain prevents me for standing at all.

7.) Social Life:
( ) Social life is normal, with no extra pain.
( ) Social life is normal, but increases degrees of pain.
( ) Pain has no significant effect of my social life apart from limiting more energetic interest. (ex dancing)
( ) Pain has restricted my social life and I do not get out often.
( ) Pain has restricted my social life at home
( ) I have no social life because of pain.

8.) Sleeping:
( ) I have no trouble sleeping
( ) My sleep is slightly disturbed (less than one (1) hour of sleep loss)
( ) My sleep is mildly disturbed (One to two (1-2) hours of sleep loss)
( ) My sleep is moderately disturbed (Two to three (2-3) hours of sleep loss)
( ) My sleep is greatly disturbed (Three to five (3-5) hours of sleep loss)
( ) My sleep is completely disturbed (Five to seven (5-7) hours of sleep loss)

9.) Traveling:
( ) I can travel anywhere without extra pain
( ) I can travel anywhere, but is causes extra pain
( ) Pain is bad, but I manage journeys over two (2) hours
( ) Pain restricts me to journeys of less than one (1) hour
( ) Pain restricts me to short necessary journeys under a half (½) hour
( ) Pain prevents me from traveling except to the doctor or hospital.

10.) Changing Degree of Pain
( ) My pain is rapidly getting better
( ) My pain fluctuates but overall is definitely better
( ) My pain seems to be getting better but improvement is slow
( ) My pain is neither getting better or worse
( ) My pain is gradually getting worse
( ) My pain is rapidly getting worse

VISUAL ANALOG SCALE (VAS) FOR PAIN – LUMBAR

Patient Name:_____

Today's Date:_____

DOB: _____Surgery Date:_____

Place a **circle on the number** indicating the **total** amount of back pain you have felt for the last week.

Low Back Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a **circle on the number** indicating the **total** amount of leg pain you have felt for the last week.

Left Leg Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a **circle on the number** indicating the **total** amount of leg pain you have felt for the last week.

Right Leg Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

CERVICAL SPINE FUNCTIONAL REPORT

PATIENT NAME: _____ DOB: _____

DATE_____ OP DATE_____

OSWESTRY RATING
CHOOSE ONE ANSWER FROM EVERY CATEGORY

1. Pain Intensity
   - ( ) I have no pain at the moment
   - ( ) The pain is very mild at the moment
   - ( ) The pain is moderate at the moment
   - ( ) The pain is fairly severe at the moment
   - ( ) The pain is very severe at the moment
   - ( ) The pain is the worst imaginable at the moment

2. Personal Care (washing, dressing, etc)
   - ( ) I can look after myself without causing extra pain
   - ( ) I can look after myself normally, but it causes extra pain
   - ( ) It is painful to look after myself and I am slow and careful
   - ( ) I need some help but manage most of my personal care
   - ( ) I need help everyday in most aspects of self care
   - ( ) I do not get dressed, wash with difficulty and stay in bed

3. Lifting
   - ( ) I can lift heavy weights without extra pain
   - ( ) I can lift heavy weights but it causes extra pain
   - ( ) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (ex: on a table)
   - ( ) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned (ex: on a table)
   - ( ) I can only lift very light weights
   - ( ) I cannot lift or carry anything at all

4. Reading
   - ( ) I can read as much as I want with no pain in my neck
   - ( ) I can read as much as I want with slight pain in my neck
   - ( ) I can read as much as I want with moderate pain in my neck
   - ( ) I cannot read as much as I want because of moderate pain in my neck
   - ( ) I cannot read as much as I want because of severe pain in my neck
   - ( ) I cannot read at all

5. Headache
   - ( ) I have no headache at all
   - ( ) I have slight headache which come infrequently
   - ( ) I have moderate headache which come infrequently
   - ( ) I have moderate headache which come frequently
   - ( ) I have severe headaches which come frequently
   - ( ) I have headaches almost all the time

PATIENT NAME: _____ DOB: _____

DATE:_____OP DATE:_____

6. Concentration
   ( ) I can concentrate fully when I want to with no difficulty
   ( ) I can concentrate fully when I want to with slight difficulty
   ( ) I have a fair degree of difficulty in concentrating when I want to
   ( ) I have a lot of difficulty in concentrating when I want to
   ( ) I have a great deal of difficulty in concentrating when I want to
   ( ) I cannot concentrate at all

7. Work
   ( ) I can do as much work as I want to
   ( ) I can only do my usual work, but no more
   ( ) I can do most of my usual work, but no more
   ( ) I cannot do my usual work
   ( ) I can hardly do any work at all
   ( ) I cannot do any work at all

8. Driving
   ( ) I can drive my car without any neck pain
   ( ) I can drive my car as long as I want with slight pain in my neck
   ( ) I can drive my car as long as I want with moderate pain in my neck
   ( ) I cannot drive my car as long as I want because of severe pain in my neck
   ( ) I can hardly drive at all because of the severe pain in my neck
   ( ) I cannot drive my car at all

9. Sleeping
   ( ) I have no trouble sleeping
   ( ) My sleep is slightly disturbed (less that 1 hour of sleep loss)
   ( ) My sleep is mildly disturbed (1-2 hours sleep loss)
   ( ) My sleep is moderately disturbed (2-3 hours sleep loss)
   ( ) My sleep is greatly disturbed (3-5 hours sleep loss)
   ( ) My sleep is completely disturbed (5-7 hours sleep loss)

10. Recreation
   ( ) I am able to engage in all my recreational activities with no neck pain at all
   ( ) I am able to engage in all my recreational activities with some pain in my neck
   ( ) I am able to engage in most but not all of my usual recreational activities because of pain in my neck
   ( ) I am able to engage in a few of my usual recreational activities because of the pain in my neck
   ( ) I can hardly do any recreational activities because of pain in my neck
   ( ) I cannot do any recreational activities at all

VISUAL ANALOG SCALE (VAS) FOR PAIN - CERVICAL

Patient Name:_____

Today's Date:_____

DOB: _____Surgery Date:_____

Place a **circle on the number** indicating the **total** amount of neck pain you have felt for the last week.

Neck Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a **circle on the number** indicating the **total** amount of arm pain you have felt for the last week.

Left Arm Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a **circle on the number** indicating the total amount of arm pain you have felt for the last week.

Right Arm Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

PHOTO ID REQUIRED

In accordance with the Federal Trade Commission regulations to reduce identity theft, we ask that you show your government issued photo identification (such as a Driver's License, Passport, or Military ID) on your next visit and all subsequent visits.

Thank you,
Sherban Orthopaedics and Spine Surgery, PLLC

To Whom it May Concern,

Enclosed please find a `Doctor`s Lien` which must be signed by you and your attorney before we can schedule a surgery date for you. We will bill your No-Fault carrier, but in the event that they deny your medical bill, we must have this Lien on file so that we can recover any outstanding amounts on your account if there is a judgment or settlement from the insurance company.

We will not be able to proceed with your surgery without this Lien on file. Please contact our office at (716) 447-6310, if you or your attorney have any questions regarding this document.

Sincerely,
Dr. Ross Sherban, D.O.

DOCTOR`S LIEN

SHERBAN ORTHOPAEDICS AND SPINE SURGERY, PLLC

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Ross Sherban D.O.

TO: ATTORNEY(S) _____

_____

_____

PATIENT NAME: _____ ***DOB:*** _____

I hereby authorize Dr. Ross Sherban to furnish you, my attorney(s), with a full report of the case history, examination, diagnosis, treatment, prognosis of myself in regard to the accident in which I was involved.

I hereby authorize and direct you my attorney(s), to pay directly to said doctor such sums as may be due and owing him/her for professional services rendered to me both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his/her office and to withhold such sums from any settlement, judgement or verdict which may be paid to you, my attorney(s), or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor`s additional protection and in consideration of pending payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

PATIENT`S SIGNATURE: _____ ***DATE:*** _____

PATIENT`S ADDRESS: _____

CITY: _____ ***STATE:*** _____ ***ZIP:*** _____

TELEPHONE: _____

Attorney(s): Please sign, date and return this document to our office as soon as possible.

The undersigned, being attorney(s) of record for the above patient, does hereby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect the said doctor named above.

Attorney(s) Signature: _____ ***Date:*** _____

Notice: Please sign, date and return to doctor`s office at once. Keep a copy for your records.

Sherban Orthopaedics and Spine Surgery PLLC

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to Sherban Orthopaedics and Spine Surgery PLLC . (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at anytime. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____ _____

Phone Number(s) (Cell/Home/Work) Email Address

PHOTO ID REQUIRED

In accordance with the Federal Trade Commission regulations to reduce identity theft, we ask that you show your government issued photo identification (such as a Driver's License, Passport, or Military ID) on your next visit and all subsequent visits.

Thank you,
Sherban Orthopaedics and Spine Surgery, PLLC