

## Sherban Orthopaedics and Spine Surgery

2914 Elmwood Ave, Kenmore NY 14217 {MAILING ADDRESS}

55 Spindrift Drive, Williamsville NY 14221

3673 Southwestern Blvd, Orchard Park NY 14127

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMAIL: \_\_\_\_\_ TELEPHONE: HOME: \_\_\_\_\_ CELL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

### No Fault {MOTOR VEHICLE ACCIDENT }

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.

<b>AUTO INSURANCE INFO</b> <b>{for the vehicle you were in at the time of the accident}</b>			
<b>Insurance Company:</b>			
<b>Insurance Company Address:</b>			
<b>Name of Policy Holder:</b>			
<b>Relationship to Policy Holder:</b>			
<b>Policy Number:</b>			
<b>NF Claim Number:</b>			
<b>NF Claim Examiner/Adjuster:</b>			
<b>Examiner/Adjuster Phone #:</b>			
<b>Examiner/Adjuster Fax #:</b>			
<b>ACCIDENT INFORMATION</b>			
<b>Date of Accident:</b>			
	<b>Were you the:</b>	<b>DRIVER</b>	<b>PASSENGER</b>
<b>Type of injury sustained:</b>			
<b>Brief Description of how accident occurred:</b>			
<b>Did you receive immediately Treatment after the accident?</b>			
<b>If no, when was the first time you sought medical treatment:</b>			
<b>Have you had ANY previous injury? (due to a car accident or workers' compensation)</b>	<b>YES</b>	<b>OR</b>	<b>NO</b>
If yes, please describe and include date of injuries, body part, and type of injury:			
<b>Since the onset of your pain, is it:</b>	<b>Better</b>	<b>Unchanged</b>	<b>Worse</b>

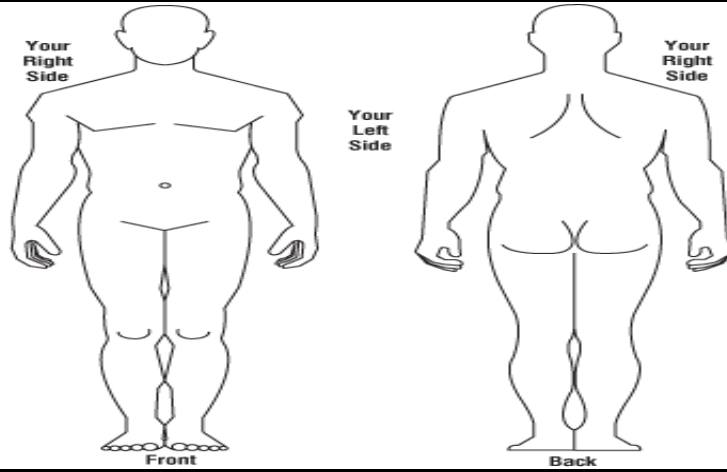
I, \_\_\_\_\_ authorize my physician/Health Care Solutions of WNY, LLC to release any information pertaining to my auto accident to my insurance (for the duration of my treatment for this incident)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Mark the areas where you feel pain and/or discomfort- RATE THE PAIN IN EACH AREA 1-10::: 1=MILD 10= SEVERE**

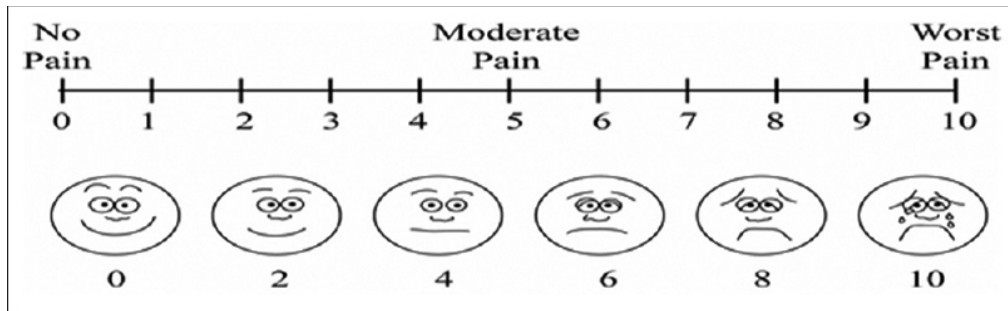
- \_\_\_\_\_ Neck
- \_\_\_\_\_ Mid Back
- \_\_\_\_\_ Low back
- \_\_\_\_\_ Shoulder (Left/Right)
- \_\_\_\_\_ Arm (Left/ Right)
- \_\_\_\_\_ Elbow (Left/Right)
- \_\_\_\_\_ Wrist (Left/Right)
- \_\_\_\_\_ Hand (Left/Right)
- \_\_\_\_\_ Hip (Left/Right)
- \_\_\_\_\_ Leg (Left/Right)
- \_\_\_\_\_ Knee (Left/Right)
- \_\_\_\_\_ Ankle (Left/Right)
- \_\_\_\_\_ Foot (Left/Right)



**PLEASE DESCRIBE THE TYPE OF PAIN YOU ARE HAVING? (CIRCLE ALL THAT APPLY)**

Sharp Aching Shooting Burning Cramping Throbbing Stabbing Itchy Sore Dull Tight Stinging

**PLEASE RATE YOUR LEVEL OF PAIN**



**Do you have any of the following?**

- |  |     |    |                       |                              |
|--|-----|----|-----------------------|------------------------------|
| *Body/muscle stiffness                                       | Yes | No | Circle which applies: | Mild-----Moderate-----Severe |
| *Radiating pain? (Pain that shoots from one area to another) | Yes | No | Describe:             | _____                        |
| *Tingling, pins and needles or burning sensations?           | Yes | No | Describe:             | _____                        |
| *Feelings of muscle weakness?                                | Yes | No | Describe:             | _____                        |
| *Any bowel/bladder changes?                                  | Yes | No | Describe:             | _____                        |
| *Increased pain from coughing or sneezing?                   | Yes | No | Describe:             | _____                        |

**What makes the pain worse? (Circle all that apply)**

Any/all activity    Bending    Running    Reaching    Lifting Weight    Prolonged Walking    Lying down/sleeping  
 Prolonged Sitting    Prolonged Standing    Changing Positions    Twisting/Rotation

**What makes the pain better? (Circle all that apply)**

Rest    Movement    Heat    Therapy    Elevation    Medication    Changing Positions    Nothing

Are you currently attending therapy?    Yes    No    If yes, where & for how long? \_\_\_\_\_

Has the therapy helped?    Yes    No    If no, why & when did you stop therapy? \_\_\_\_\_

**What type of therapy? (Circle all that apply)**

Chiropractic    Therapy: Physical and/or Occupational    Acupuncture    Modalities-Ultrasound, Electrical Stim, Hot/Cold packs

**Have you had any type of injections for this problem?**    Yes    No

If so, what type of injections did you have? (Circle all that apply)    **Did the injections help?**    Yes    No

Epidural Injection    Trigger Point Injections; Location: \_\_\_\_\_    Facet Injections    Other: \_\_\_\_\_

**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\*\*\***

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

\*\*\*\*\*

PATIENT NAME : \_\_\_\_\_

ADDRESS : \_\_\_\_\_

TELEPHONE : HOME : \_\_\_\_\_ CELL : \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH : \_\_\_\_\_ SEX : MALE : \_\_\_\_\_ FEMALE : \_\_\_\_\_

SOCIAL SECURITY NUMBER : \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

**NAME :** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_

**TELEPHONE : HOME :** \_\_\_\_\_ **CELL :** \_\_\_\_\_

\*\*\*\*\*

**PRIVATE INSURANCE INFORMATION**

PRIMARY INSURANCE : \_\_\_\_\_

ID# : \_\_\_\_\_ Suffix: \_\_\_\_\_ GROUP# : \_\_\_\_\_

Responsible Party: \_\_\_\_\_ DOB: \_\_\_\_\_

SECONDARY INSURANCE : \_\_\_\_\_

ID# : \_\_\_\_\_ Suffix: \_\_\_\_\_ GROUP# : \_\_\_\_\_

Responsible Party: \_\_\_\_\_ DOB: \_\_\_\_\_

**CORRESPONDENCE INFORMATION**

\*\*\*\*\*IMPORTANT INFORMATION NEEDED\*\*\*\*\*

PRIMARY MEDICAL DOCTOR: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

ATTORNEY INFORMATION: \_\_\_\_\_

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.

**NO SHOWS:**

Please be advised that a fee of \$75.00 will be charged to patients who fail to show for a scheduled appointment without giving us one business day's notice by phone (716-447-6310). The patient must speak with someone in the office to cancel his/her appointment.

\*PLEASE NOTE THAT YOUR INSURANCE COMPANY WILL NOT COVER THIS CHARGE - THIS POLICY IS INTENDED TO FACILITATE BEST SCHEDULING PRACTICES AND ENABLE OUR PROVIDERS AND OUR STAFF TO MAXIMIZE THE TIME AVAILABLE FOR PATIENT CARE

\_\_\_\_\_  
Patient name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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DATE: \_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE**

**MEDICATIONS:** Please list your most current medications and who prescribes them:


**\*\*\*\*\*ALLERGIES:** \_\_\_\_\_

**SOCIAL HISTORY: ALCOHOL:**

DO YOU DRINK? Y OR N IF YES, HOW MUCH AND HOW OFTEN: SOCIAL / OCCASIONAL / MODERATE

**SMOKING AND CHEWING TOBACCO:** DO YOU SMOKE? Y or N < PACK A DAY \_\_\_ 1-2 PACKS A DAY \_\_\_ >3 PACKS A DAY \_\_\_

CHEWING TOBACCO \_\_\_ PREVIOUS SMOKER: Y or N WHEN DID YOU QUIT? \_\_\_\_\_

**Surgical History & The Date Performed:**

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

**AUTHORIZATION AND RELEASE:**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Narcotic Medication Agreement**

I, \_\_\_\_\_ understand that:

- **I will call the office FIVE (5) business days ahead of my refill date. P# 716-447-6310.**
- 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.
- You 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.
- Early refill requests will NOT be honored & I will take my medication **ONLY** as prescribed.
- 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: \_\_\_\_\_

**NEW YORK MOTOR VEHICLE INSURANCE FORM  
ASSIGNMENT OF BENEFITS**

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

I, \_\_\_\_\_ ("Assignor") hereby assign to **Sherban Orthopaedics and Spine Surgery, PLLC/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** not withstanding 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 SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
PATIENT ADDRESS



\_\_\_\_\_  
Electronically Signed by:  
Dr. Ross Sherban, D.O.  
Fellowship Trained Orthopaedic Spine Surgeon

\_\_\_\_\_  
(DATE)

**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.**



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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.

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(Signature of Patient/ Insured)

---

(Date Signed)

---

(Representative of Sherban Orthopaedics and Spine Surgery, PLLC)

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DATE: \_\_\_\_\_

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

**General Information:**

**Information about your treatment and care, including payment for care, is protected by two federal laws:**

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Confidentiality Law. Under these laws the practice must obtain your written consent before it can disclose information about you for payment purposes. For example, the practice must obtain your written consent before it can disclose any Personal Health Information (PHI). In addition, you must also sign a written consent before the practice can share information for any and all treatment purposes. However, federal law permits the practice to disclose information in the following circumstances without your written permission:

1. To practice staff for the purposes of maintaining the clinical records
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, your insurance company)
3. For research, audit or evaluations (e.g. State licensing review, or accreditation as required by the State and/or Federal government);
4. To report a crime committed on the practice's premises or against practice staff
5. To medical personnel in a medical/psychiatric emergency
6. To appropriate authorities to report suspected child abuse or neglect
7. To report certain infectious illnesses as required by state law
8. Information that is requested per a court order

Before the practice can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

**Disclosure of Medical Information**

I give my permission to the office of Sherban Orthopaedics and Spine Surgery, PLLC to disclose medical information regarding my treatment/diagnosis to the following family members or friends whom you may speak with:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**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 any time. 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:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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Phone: 716-447-6310  
Fax: 716-775-6288  
[WWW.DRSHERBAN.COM](http://WWW.DRSHERBAN.COM)

## DR. ROSS SHERBAN

Fellowship Trained Orthopedic Spinal Surgeon  
Board Certified Orthopedic Surgeon  
AOSpine  
American Medical Association  
North American Spine Society  
American Osteopathic Association  
Association of Orthopedic Surgeons  
American Academy of Orthopedic Surgeons  
American Osteopathic Academy of Orthopedics

## DR. RODRIGO CASTRO

**Medical Director**  
Board Certified Physician  
North American Spine Society  
American Osteopathic Association  
American Academy of Family Physicians

## MICHAEL JENKINS PA-C

Certified Physician's Assistant

## DR. R. WARREN ROGERS

Fellowship Trained Orthopedic Spinal Surgeon  
Board Certified Orthopedic Surgeon  
North American Spine Society  
American Osteopathic Association  
American Academy of Orthopedic Surgeons  
American Osteopathic Academy of Orthopedics

### 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: **Sherban Orthopaedics and Spine Surgery.** 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:** \_\_\_\_\_

# CERVICAL SPINE FUNCTIONAL REPORT

\*\*\*\*\*PLEASE ONLY FILL OUT IF YOU ARE TREATING FOR YOUR NECK\*\*\*\*\*

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

## 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 than 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 <b>circle on the number</b> indicating the <b>total</b> amount of neck pain you have felt for the last week.
<b>Neck Pain</b>
No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a <b>circle on the number</b> indicating the <b>total</b> amount of arm pain you have felt for the last week.
<b>Left Arm Pain</b>
No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a <b>circle on the number</b> indicating the <b>total</b> amount of arm pain you have felt for the last week.
<b>Right Arm Pain</b>
No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

## LUMBAR SPINE FUNCTIONAL REPORT

\*\*\*\*\*PLEASE ONLY FILL OUT IF YOU ARE TREATING FOR YOUR LOW BACK\*\*\*\*\*

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 lift 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 ( $\frac{1}{2}$ ) a mile.
- Pain prevents me from walking more than a quarter ( $\frac{1}{4}$ ) 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 ( $\frac{1}{2}$ ) 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 ( $\frac{1}{2}$ ) 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 it 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 ( $\frac{1}{2}$ ) 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



## **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**

<b>Patient First Name</b>																											
<b>Patient Last Name</b>																											
<b>Date of Birth</b>				<b>Patient Address</b>				<b>Gender</b>																			
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M	M	D	D	Y	Y	Y	Y																				
				City _____ State _____ Postal Code _____																							

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at [www.wnyhealthelink.com](http://www.wnyhealthelink.com).

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

S E L E C T  O N L Y  O N E	<b>My Consent Choice. Only ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.</b>			
	<input type="checkbox"/> <b>1. YES</b>	<b>I GIVE CONSENT</b> to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.		
	<input type="checkbox"/> <b>2. YES, EXCEPT SPECIFIC PARTICIPANT(S)</b>	<b>I GIVE CONSENT</b> to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, <b>EXCEPT</b> the Participant(s) listed below. Participant's Name (Provider Office): _____ Participant's address or phone number: _____ <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> </table>		
<input type="checkbox"/> <b>3. YES, ONLY SPECIFIC PARTICIPANT(S)</b>	<b>I GIVE CONSENT ONLY</b> to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): _____ Participant's address or phone number: _____ <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td></tr> </table>			
<input type="checkbox"/> <b>4. NO, EXCEPT IN AN EMERGENCY</b>	<b>I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY</b> for current and future Participants to access my electronic health information through HEALTHeLINK.			
<input type="checkbox"/> <b>5. NO, EVEN IN AN EMERGENCY</b>	<b>I DENY CONSENT</b> for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, <b>even</b> in a medical emergency.			

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

**Signature of Patient or Patient's Legal Representative**

X \_\_\_\_\_

**Date of Signature**

M	M	D	D	Y	Y	Y	Y

**Print Name of Patient's Legal Representative (if applicable)**


\_\_\_\_\_

**Relationship of Legal Representative to Patient (if applicable)**

Parent       Healthcare agent/proxy  
 Guardian       Other \_\_\_\_\_

**This Box To Be Filled Out Only By The Provider**

Sherban Orthopaedics and Spine Surgery



Entity Consent Received By \_\_\_\_\_

**Witness\***

\*Required if NOT completing this form in a Participant's office.

Print Name of Witness \_\_\_\_\_ Signature of Witness \_\_\_\_\_

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.) \_\_\_\_\_

## Details about patient information in HEALTHeLINK and the consent process:

- 1. How Your Information May Be Used.** With limited exceptions, if you give consent, the Participant(s) you approve may use your electronic health information **only** for the following healthcare services:
  - **Treatment Services.** Provide you with medical treatment and related services.
  - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
  - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
  - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.
- 2. What Types of Information About You Are Included.** If you give consent, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
  - Alcohol or drug use problems
  - HIV/AIDS
  - Birth control and abortion (family planning)
  - Genetic (inherited) diseases or tests
  - Mental health conditions
  - Sexually transmitted diseasesIf you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.
- 3. Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other eHealth organizations that exchange health information electronically. A complete list of current Information Sources is available from HEALTHeLINK at [www.wnyhealthelink.com](http://www.wnyhealthelink.com) or by calling 716- 206-0993 ext. 311.
- 4. Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Participant(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may only be accessed where there is a treating provider relationship. A complete list of Participants is available from HEALTHeLINK at [www.wnyhealthelink.com/PhysiciansandStaff/CurrentParticipants/ParticipatingHEALTHeLINKProviders](http://www.wnyhealthelink.com/PhysiciansandStaff/CurrentParticipants/ParticipatingHEALTHeLINKProviders) or by calling 716-206-0993 ext. 311 if you want a hard copy which will be provided at no charge within 5 business days of the request.
- 5. Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call one of the Participants you have approved to access our records; or visit HEALTHeLINK's website at [www.wnyhealthelink.com](http://www.wnyhealthelink.com); or call HEALTHeLINK at 716- 206-0993 ext. 311; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.
- 6. Re-disclosure of Information.** Any Participant(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.
- 7. Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HEALTHeLINK ceases operation (**or until 50 years after your death whichever occurs first**). If HEALTHeLINK merges with another Qualified Entity our consent choices will remain effective with the newly merged entity.
- 8. Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Participant(s) that access your health information through HEALTHeLINK while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.