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

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

Workers' Compensation Patients

Understand that without majority of the below information, you or your back-up insurance may be billed in lieu of missing information about your Workers' Compensation 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 Human Resources representative at your company. They will assist you.

WC Carrier Name:	
WC Carrier Address:	
WC Carrier Phone:	
WC Carrier Fax:	
WC Carrier ID NUMBER	**W** ___ ___ ___ ___ ___ ___
Date of Injury:	
WC CASE/Claim Number:	
WC Board Number:	___ ___ ___ ___ ___ ___ ___ ___
WC Claim Examiner/Adjuster:	
Examiner/Adjuster Phone #:	
Examiner/Adjuster Fax #:	
Employer's Name:	
Employer's Address:	
Job Title:	
Employment Status:******	
Brief Description of how accident occurred:	
Did you receive treatment immediately after the accident? If no, when was the first time you sought medical treatment:	
Have you had ANY previous injury? *(due to a car accident or workers' compensation)* **YES OR NO** If yes, please describe and include date of injuries, body part, and type of injury:	
Since the onset of your pain, is it:	**Better Unchanged Worse**

I,_____ authorize my physician/Health Care Solutions of WNY, LLC to release any information pertaining to my work related injury to my employer, Workers' Compensation insurance carrier and the Workers' Compensation Board (for the duration of my treatment for this incident)

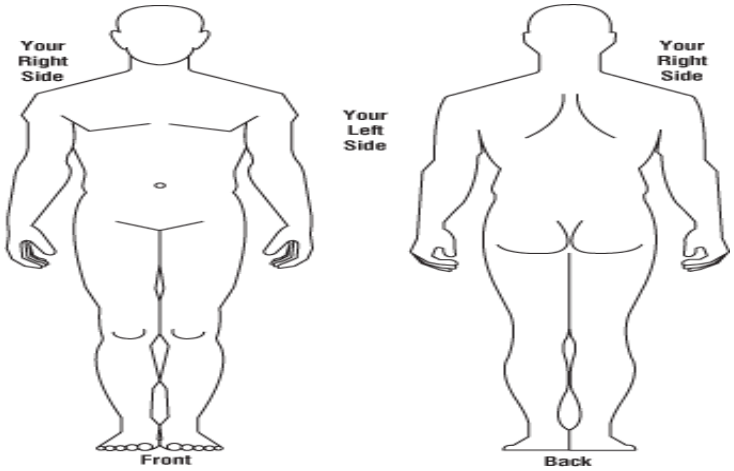
You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered. I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Signature:_____ Date:_____

Physician Office: SHERBAN ORTHOPAEDIC AND SPINE SURGERY, PLLC

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

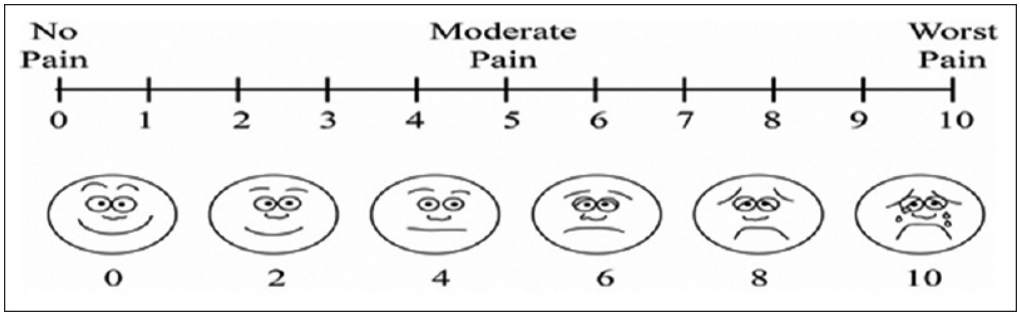
_____Neck
_____Mid Back
_____Low back
_____Shoulder (Left/Right)
_____Arm (Left/ Right)
_____Elbow (Left/Right)
_____Wrist (Left/Right)
_____Hand (Left/Right)
_____Hip (Left/Right)
_____Leg (Left/Right)
_____Knee (Left/Right)
_____Ankle (Left/Right)
_____Foot (Left/Right



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:_____

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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 : _____

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:

_____

_____

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:_____

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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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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: _____

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 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

******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 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

HEALTHeLINK **Authorization for Access to Patient Information Through HEALTHeLINK**

Patient First Name

Patient Last Name

Date of Birth M M / D D / Y Y Y Y

Patient Address

Street _____ Apartment _____

City _____ State _____ Postal Code _____

Gender

☐ Male

☐ Female

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.

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.

SELECT ONLY ONE

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.

☐ **1. YES** — **I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.

☐ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)** — **I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below.

Participant's Name (Provider Office):	Participant's address or phone number:

☐ **3. YES, ONLY SPECIFIC PARTICIPANT(S)** — **I GIVE CONSENT ONLY** 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:

☐ **4. NO, EXCEPT IN AN EMERGENCY** — **I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.

☐ **5. NO, EVEN IN AN EMERGENCY** — **I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, ***even*** 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 diseases

   If 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 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 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; 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.