R MICHAEL KOCH, MD BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGERY

BRAIN & SPINE SURGEONS OF NEW YORK - INSURANCE INFORMATION

NAME:		MARITAL STATUS
STREET ADDRESS:		(CIRCLE ONE) M S D W
CITY:	STATE:	ZIP
HOME PHONE #: ( )	CELL #: ( )	WORK PHONE #: ( )
DATE OF BIRTH: AGE:	SEX: MALE ( ) FEMALE ( )	
SOCIAL SECURITY #:		OCCUPATION:
NAME OF EMPLOYER:		
STREET ADDRESS:		
CITY:	STATE:	ZIP
EMAIL:		
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE#:
REFERRED BY:	PHONE #:	

WORKMEN'S COMPENSATION	**NO FAULT**
WERE YOU HURT ON THE JOB?	AUTOMOBILE ACCIDENT?
EMPLOYER AT TIME OF INJURY:	
INSURANCE COMPANY:	INSURANCE COMPANY:
INSURANCE ADDRESS:	INSURANCE ADDRESS:
CITY/STATE/ZIP:	CITY/STATE/ZIP:
CARRIER TELEPHONE #:	CARRIER TELEPHONE #:
CARRIER FAX #:	ADJUSTER NAME:
CC#: WCB#:	FILE #:
ADJUSTER NAME:	INSURED:
DATE OF ACCIDENT:	DATE OF ACCIDENT:
ATTORNEY NAME:	
ATTORNEY ADDRESS/TELEPHONE #:	

OBTAIN THIS INFORMATION FROM YOUR INSURANCE ID CARD OR FORM

PRIMARY INSURANCE:		
INSURED NAME:	INSURED SS#:	
INSURED DATE OF BIRTH:	INSURED I.D.#:	
RELATIONSHIP TO INSURED:	EMPLOYER:	OCCUPATION:
SECONDARY INSURANCE:		
INSURED NAME:	INSURED SS#:	
INSURED DATE OF BIRTH:	INSURED I.D.#:	
RELATIONSHIP TO INSURED:	EMPLOYER:	OCCUPATION:

I verify the accuracy of the above information and I authorize the release of information as provided on the reverse side of this form

PATIENT SIGNATURE & DATE

I am in agreement with "Responsibility to Pay" and the "Authorization to Pay" statement on the reverse side of this form.

PATIENT SIGNATURE & DATE

RESPONSIBILITY FOR PAYMENT:

I understand that I am ultimately responsible for any and all charges for physician, including deductible and co-insurance, unless the physician participates in my medical insurance plan, which I certify is currently active.

AUTHORIZATION TO RELEASE MEDICAL RECORDS:

I authorize my physician to release any and all of my medical records, as per "NOTICE OF INFORMATION PRACTICES" executed by me, including but not limited to medical history, records of office visits and treatment rendered, clinical laboratory reports, diagnostic test results and imaging reports.

Such records must be released to my attorney on my request, another physician, or any other health care professional for the purposes of discussing my condition, consulting on my case, or reviewing my medical records for further treatment.

These records may also be released to any governmental agencies, insurance companies and employees of insurance companies for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to me, or performing quality assurance reviews as required by law.

These records may also be released by my medical insurance plan to any agency for the purpose of pursuing payment, insurance reimbursement, submitting claims for services rendered or to be rendered to me, or performing quality assurance reviews as required by law.

If coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entity this authorization also permits disclosure to them if requested for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect until revoked in writing. This authorization shall be binding upon me, my dependents, heirs, executors and administrators.

MEDICARE/MEDICAID:

I request that payment of authorized benefits be made to this office for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

AUTHORIZATION TO PAY:

I request that the physician bill and request payment directly from the insurance company(s) which I have indicated on the reverse side of this form.

R. MICHAEL KOCH, M.D., FACS

BOARD CERTIFIED PLASTIC & RECONSTRUCTIVE SURGERY

BRAIN AND SPINE SURGEONS OF NEW YORK

Height: _____ Weight: _____

Primary Care Physician Name: _____ Phone Number _____

Primary Care Physician Address: _____

Reason you are seeing the doctor today: _____

List any medical conditions that you are currently being treated for:

List any medications you are currently taking (please include dosage and frequency):

List any allergies that you have, including medication allergies and please describe the reaction you get: _____

List any surgical procedures you have had, please note the year performed:

Have you had any problems with anesthesia in the past? Yes or No

How much do you smoke (packs per week)? _____ How much alcohol do you drink in a week? _____

List medical history in immediate family members:

Do you have a family history of breast cancer?: YES or NO .....If yes, who? _____ Last Mammogram: _____

Do you have any children?: Yes or No .....If yes, how many? _____ What are their ages? _____

Have you ever had a colorectal screening? YES or NO

Have you had, or are you being treated for any of the following conditions or medical problems?

Sinus Problems?	Y	N	Stiffness of neck/back?	Y	N	Nervous breakdown?	Y	N
Bleeding from nose?	Y	N	Difficulty opening mouth?	Y	N	Anxiety attacks?	Y	N
Palpitations?	Y	N	Muscle weakness?	Y	N	Intolerance to cold?	Y	N
Chest Pain?	Y	N	Skin rashes?	Y	N	Diabetes?	Y	N
Tuberculosis?	Y	N	Color changes in skin?	Y	N	Thyroid condition?	Y	N
Pneumonia?	Y	N	Seizures?	Y	N	Hepatitis?	Y	N
Emphysema?	Y	N	Loss of coordination?	Y	N	Anemia?	Y	N
Jaundice?	Y	N	Convulsion?	Y	N	Blood Transfusion?	Y	N
Stomach ulcers?	Y	N	Loss of control of limbs?	Y	N	Enlarged lymph nodes?	Y	N
Hiatal Hernia?	Y	N	Hoarseness?	Y	N	Abnormal bleeding?	Y	N
Kidney stones?	Y	N	Dizziness?	Y	N	Hay fever?	Y	N
Kidney failure?	Y	N	Shortness of breath?	Y	N	Pacemaker?	Y	N
Urinary frequency?	Y	N	High blood pressure?	Y	N	Swelling of feet/ankles?	Y	N
Urinary retention?	Y	N	Loss of sensation?	Y	N	Asthma?	Y	N
Arthritis?	Y	N	Sleep disturbance?	Y	N	Rheumatic fever?	Y	N
Joint pain?	Y	N	Hallucinations?	Y	N	Irregular heartbeats?	Y	N
Joint swelling?	Y	N	Migraines?	Y	N			

Patient's or Legal Guardian's Signature _____ **Print Name:** _____ **Date** _____

BRAIN & SPINE SURGEONS OF NEW YORK, P.C.

I hereby acknowledge that I have received and read the information documenting my rights as a patient and the responsibilities of Brain & Spine Surgeons of New York under the Health Insurance Portability and Accountability Act of 1996.

Patient's signature _____

Print Name _____

Date _____

Please list any family and/or friends with whom we may discuss your medical condition, demographic information, diagnosis, and /or financial account if necessary:

Name: _____

Relationship _____ Phone Number: _____

Name: _____

Relationship _____ Phone Number: _____

Name: _____

Relationship _____ Phone Number: _____

BRAIN & SPINE SURGEONS OF NEW YORK, P.C.

4 Westchester Park Drive White Plains NY 10604
Phone: 914-948-3008 fax: 914-948-0351

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

BRAIN & SPINE SURGEONS OF NEW YORK, PC

GROUP NPI: _____
GROUP TAX ID #: _____

Business Office

AUTHORIZATION FOR PROVIDER APPEAL

Date: _____

I _____ hereby authorize

Brain and Spine Surgeons Of New York, PC to appeal on my behalf to my

insurance carrier _____ and/or any third party

administrator responsible for processing, pricing, or clinical review of medical

claims for myself or my dependents.

Signed: _____

Name: _____

Policy Number: _____

Date of Birth: _____

4 Westchester Park Drive
4th floor
White Plains, NY 10604
Tel: 914-948-8003
Fax: 914-686-5478

BRAIN & SPINE SURGEONS OF NEW YORK

Brain and Spine Surgery
John M. Abrahams, M.D.
Kaushik Das, M.D.
Alain C.J. de Lotbinière, M.D.
Kent R. Duffy, M.D.
Virany Hillard, M.D.
Ezriel E. Kornel, M.D.
Raj Murali, M.D.
Craig Shannon, M.D.
Jack Stern, M.D.
Adesh Tandon, M.D.
Peter A. Zahos, M.D.
William Wirchansky, M.D.

Pediatric Neurosurgery
Avinash Mohan, M.D.
Michael Tobias, M.D.

Orthopedic Spinal Surgery
Seth L. Neubardt, M.D.
Krishn M. Sharma, M.D.
Rudolph F. Taddonio, M.D.

Plastic & Reconstructive Surgery
R. Michael Koch, M.D.

To All of Our Patients:

In these difficult financial times many of us are being forced to make decisions based on what we can *afford* rather than what is good for us. We, the physicians at Brain & Spine Surgeons of New York, believe that our patients are entitled to the best medical care possible, for this reason we have amended our billing policies as follows:

1) We will bill your insurance for you, rather than expect you to pay the **surgery** bill yourself. We will wait until your insurance makes their full payment rather than turn to you for payment. Please note that many insurance companies have arbitrarily reduced their fees and delayed their payment cycles. We may request your assistance in intervening with your insurance company in order to expedite payment and reduce your out of pocket expenses.

2) While we are working with your insurance company you will receive a Statement from us each month, which will show you our progress in collecting your bill. Should you receive payment directly from your insurance company during this period please forward the payment to our office immediately so that we may correct your Statement.

3) When your insurance has finished paying us we are *obligated by law* to send you a bill for the balance. Should paying this bill present a financial hardship to you please do not hesitate to call one of our Patient Account Representatives at (914) 948-8003. We do not want any of our patients to make an important medical decision based on their ability or inability to pay for the care they need.

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Craig Shannon, M. D.
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R. Michael Koch, M.D.
Michael Shannon, M.D.

4 Westchester Park Drive 4th floor
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Business Office Telephone: 914-948-8003
Business Office Fax: 914-686-5478