**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*
*Chihiro Shinohara, PA-C*
*Board Certified Plastic and Reconstructive Surgery*

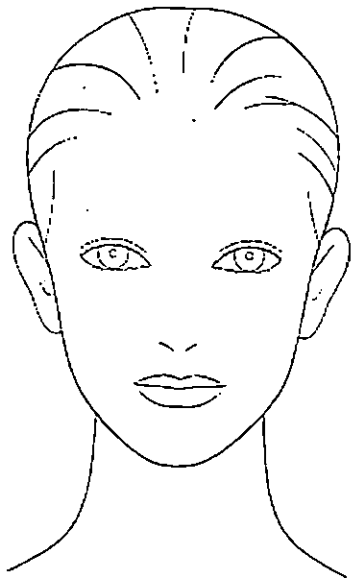
## Injectable/Botox Interest

Patient Name:_____ DOB_____ Date:_____

**Reason why you are seeing the doctor today:** _____

_____

What areas bother you the most? (Please circle on the Right)



Have you ever gotten injectables or Botox ® previously? Yes / No

Have you gotten any complications from this? Yes / No

What were they? _____

Please list any medical conditions you have:

_____

_____

_____

Please list any medications you are currently taking:

_____

_____

Please list any allergies you have:

_____

_____

Please list any surgeries you have had in the past:

_____

_____

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

Do you have any allergies to eggs? Yes / No

Do you have any history of significant bruising/bleeding? Yes / No

Do you have any history of neuromuscular disorders? Yes / No

Do you smoke cigarettes? Yes, packs per week:_____ / No

Do you consume alcohol? Yes, glasses per week:_____ / 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 or Legal Guardian's Signature: _____ Date:_____

Print Name: _____

# 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: _____