



**JOHN L. XETHALIS, M.D.**  
**NEW PATIENT/UPDATE INTAKE FORMS**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Sec #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_S\_\_\_M\_\_\_D\_\_\_Sep  
Address: \_\_\_\_\_ APT#: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email Address: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  **Decline to Answer**

**EMPLOYER INFORMATION**

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_

**EMERGENCY CONTACT**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship: \_\_\_\_\_ Address: \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

***Is the injury work related, a car accident, or as a result of playing a sport at school? \_\_Yes\_\_ No***  
***If yes, please circle one of the following: \_\_Work Related\_\_ Car Accident\_\_Sports Injury***

**INSURANCE INFORMATION**

*Primary Insurance: Plan/Company:* \_\_\_\_\_ *Policy #:* \_\_\_\_\_

Group #: \_\_\_\_\_  Self  Spouse  Dependent  Other

Policy Holder: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

*Secondary Insurance: Plan/Company:* \_\_\_\_\_ *Policy #:* \_\_\_\_\_

Group #: \_\_\_\_\_  Self  Spouse  Dependent  Other

Policy Holder: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

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



**JOHN L. XETHALIS, M.D.**

**Primary Care Physician:** (Name, Address, Tel) \_\_\_\_\_ Age: \_\_\_\_\_  
**Pharmacy:** (Name, Address) \_\_\_\_\_ Height: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_ Weight: \_\_\_\_\_

**REASON FOR TODAY'S VISIT**

What is the reason for today's visit? (Include Right or Left) \_\_\_\_\_  
When did your symptoms start? \_\_\_\_\_ Dominant Hand:  Right  Left  
Current pain level: (please circle) (least severe) 0 1 2 3 4 5 6 7 8 9 10 (most severe)  
When do the symptoms occur? \_\_\_\_\_ Associated symptoms: \_\_\_\_\_  
What makes your symptoms better? \_\_\_\_\_ Prior treatment for this injury: \_\_\_\_\_  
Did this injury occur at work?  Yes  No Auto Accident?  Yes  No School Injury?  Yes  No

**PAST MEDICAL HISTORY**

Medical Conditions: \_\_\_\_\_  
Previous Surgeries: (Include date) \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Drug Allergies: (Include reaction) \_\_\_\_\_  
Family Medical History: (Include condition and relative) \_\_\_\_\_  
Social History: Alcohol Use:  None  Occasionally  Daily  Heavy Drug Use:  None  \_\_\_\_\_  
Tobacco Use:  Never  Current (Packs per day: \_\_\_\_\_)  Former (Years: \_\_\_\_\_ to \_\_\_\_\_)

Review of Symptoms: (Have you experienced any of the following over the past 6 months?)

Fever/Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clot/DVT	<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that the above is correct and complete to the best of my knowledge.

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

(This section is for physician use only)

**Exam:**

**Imaging:**

**A/P:**

**Physician Signature:** \_\_\_\_\_



## Financial Policy

Thank you for choosing \_\_\_\_\_ as your health care provider. Our practice is committed to delivering the best treatment possible for each of our patients. Your clear understanding of our financial policy is important to our professional relationship, and allows us to concentrate on patient care.

### Insurance

We must emphasize that as medical care providers; our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges from the date the service is rendered are your responsibility. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract.

If the physician participates with your managed care medical insurance, please remember your co-payment is due at the time of service. This is a requirement of your insurance company. Please remember to have all necessary referrals completed prior to your appointment. If your insurance requires prior authorization or referral for any of your visits or treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred or your visit can be rescheduled.

If we do not participate with your insurance company, payment for office visits is due at the time of service. However, we will bill surgical procedures to this insurance for you as a courtesy. Please be aware that you will continue to receive statements from us until your account is paid in full. This will alert you that the insurance company has not yet sent payment to us on your behalf. Your insurance company may send the payment to you, the insured, not the physician. It is your responsibility to forward both the payment and the accompanying explanation of benefits to our office. This will allow our billing office to post accurate payments and reconcile your account.

### Canceled Appointments

It is important that you keep your scheduled appointments. If you are unable to do this, please call our office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged \$50.00.

### Dependent Children

The responsibility of payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of the practice.

### Workers Compensation/ No Fault

Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment from the patient will be expected until the practice is provided with all the information necessary to submit a claim. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing office promptly for assistance in the management of your account. If you have any questions or need any additional information regarding our financial policy, please do not hesitate to call our billing office at (212)737-3301.

### Payment

I hereby authorize and instruct the insurance company(s) noted to pay authorized benefits on my behalf to **NY Orthopedics**. This payment will not exceed my current indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment amount. I also authorize the release of any medical information required to process payment claims.

I have read and understand the above financial policy:

Patient Name (Print): \_\_\_\_\_

Parent/ Guardian Name (Print): \_\_\_\_\_

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

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



## Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **NY Orthopedics** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

Fundraising: Unless you request us not to, we may use your name and address to support Lenox Hill Hospital and NISMAT fundraising efforts. If you do not want to participate in fundraising efforts, please check off the following box.

I do not wish to participate in fundraising efforts

### Notice of Privacy Practices

You should review the Notice of Privacy Practices for more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

### Requesting a restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. NY Orthopedics may or may not agree to restrict the use or disclosure of your protected health information. If NY Orthopedics agrees to your request, the restrictions will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal policy standards.

### Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing, any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### Reservation of Rights to Change Privacy Practices

NY Orthopedics reserves the right to modify the privacy practices outlined in the notice.

### Signature

I have reviewed this consent form and received a copy of Notice of Privacy Practices. I give my permission to NY Orthopedics to use and disclose my health information in accordance with it. Additionally, I agree that NY Orthopedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Patient's Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Signature of patient representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

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



## Patient Request for Confidential Communication

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Patient Address: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Social Sec #: \_\_\_\_-\_\_\_\_-\_\_\_\_

NY Orthopedics may contact you by telephone at your home, work or cell unless you instruct us otherwise.

**Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obliged to honor it, except if any emergency arises.**

I wish to be contacted as follows (check all that apply)

At my home telephone number (\_\_\_\_) \_\_\_\_-\_\_\_\_

Leave me a message with a call back number only

At my work telephone number (\_\_\_\_) \_\_\_\_-\_\_\_\_

Leave me a message with a call back number only

On my cell phone number (\_\_\_\_) \_\_\_\_-\_\_\_\_

Leave me a message with a call back number only

Send a message reminder via text message

Send a message reminder via email

Email: \_\_\_\_\_

Other: Please specify any other person(s) allowed to contact our office on your behalf:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Print Name: \_\_\_\_\_

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

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

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



## Financial Disclosure Form

*Out of Network, Lack of Referral, Non Participating Provider*

I, (print name) \_\_\_\_\_, hereby attest that I fully understand my financial responsibility for the charges resulting from my decision to do the following:

- I choose to use a specialist (name of doctor) \_\_\_\_\_, who **does not** participate in (name of insurance carrier) \_\_\_\_\_.
  
- I choose to see an **in network** specialist (check one)  **with/**  **without** an authorized referral from my Primary Care Physician. The specialist I will see is \_\_\_\_\_.

I understand that my financial liability will be determined by the provisions of my coverage plan.

Date of service: \_\_\_\_\_

Member name: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Member/ Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_