# NICHOLAS A. WESSLING, 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: _____

# NICHOLAS A. WESSLING, 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 | ☐ Yes ☐ No | Shortness of breath | ☐ Yes ☐ No | Seizures | ☐ Yes ☐ No |
| Blurred Vision | ☐ Yes ☐ No | Heartburn | ☐ Yes ☐ No | Depression | ☐ Yes ☐ No |
| Nose Bleeds | ☐ Yes ☐ No | Joint Stiffness | ☐ Yes ☐ No | Easy Bleeding | ☐ Yes ☐ No |
| Chest Pain | ☐ Yes ☐ No | Skin Rash | ☐ Yes ☐ No | Blood Clot/DVT | ☐ Yes ☐ No |

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

Patient Signature: _____ Date: _____

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**(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 case.

***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 pf 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: _____