HMP Orthopedics, P.C.
Richard E. Pearl, M.D.
50 East 77TH St., Apt 1C
New York, NY 10075

RICHARD E PEARL,M.D. ANGEL LEAL. PA

MEDICAL RELEASE AUTHORIZATION AND INSURANCE ASSIGNMENT

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to HMP ORTHOPAEDICS, P.C. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account.

I request that payment for authorized Medicare benefits be made either to me or on my behalf to HMP ORTHOPAEDICS, P.C. for any services or supplies furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to my insurance company in order to determine insurance benefits to which I may be entitled. I may revoke this authorization at any time in writing.

I authorize HMP ORTHOPAEDICS, P.C. to release and/or send medical information regarding my case to other consulting and/or referring physicians.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that my insurance is a contract between the insurance carrier, and me and not between the insurance carrier and this office, and that I am still fully responsible for all fees. Late fees will be assessed on balances not paid by due date. Should timely payments of this account not be made, I authorize HMP ORTHOPAEDICS, P.C. to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility.

I understand that I will be charged an administrative fee of $25.00 by HMP ORTHOPAEDICS, P.C for completion of any forms required by you or your insurance provider. These forms include, but are not limited to statements of medical necessity, prescription precertifications, prescription refills requiring these statements, life insurance forms, disability insurance forms and any non-claim insurance forms.

_____

Print Full Name

X _____ _____

Signature *Date*

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Please tell us how you heard about us:

☐ I am a Previous Patient

☐ Referring Physician
Please Specify _____

☐ Primary Physician
Please Specify _____

☐ Internet
PleaseSpecify _____

☐ Family/Friend
PleaseSpecify _____

☐ Insurance
PleaseSpecify _____

☐ Other
PleaseSpecify _____

☐ NYC Triathlon Expo

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Patient Request for Confidential Communication

Patient Name: _____ DOB:___/___/____

Patient Address: _____

Phone: (___)_____ Social Sec#: _____

MOSM 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)

☐ via Email: _____ **We may use your email to contact you.**

☐ 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

☐ At my cellphone number (___)_____

☐ Leave me a message with a call back number only

☐ Send a message reminder via text message

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

_____ _____

_____ _____

Patient Name: _____ Date: _____

Signature: _____

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Name_____ D OB_____

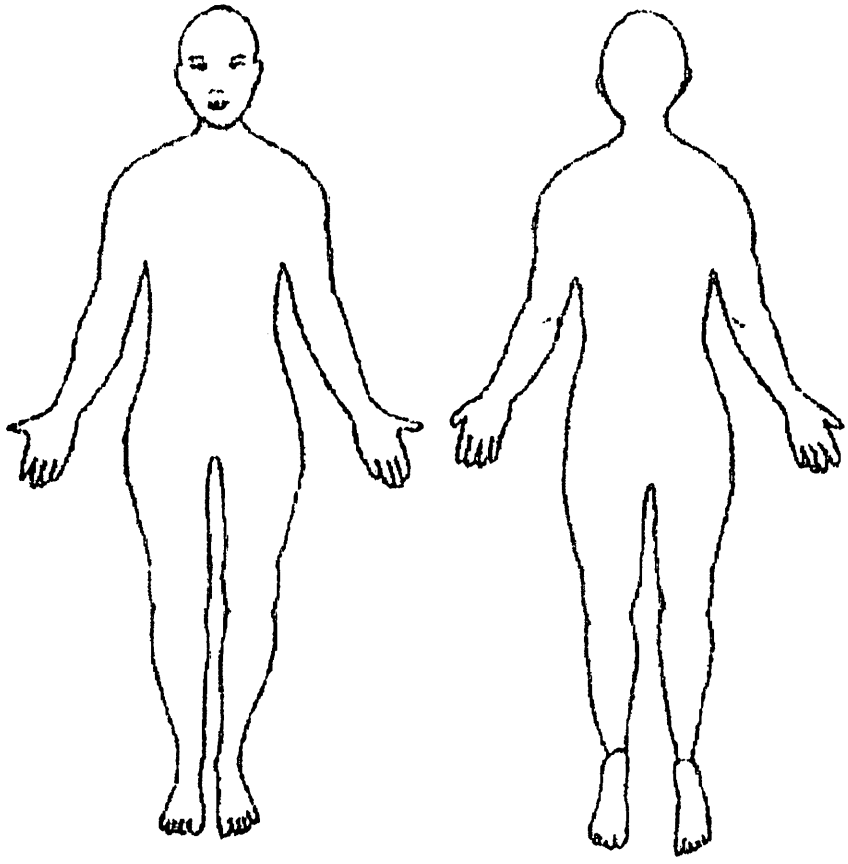
Description of Current Problem/Illness

Location of Problem (please indicate by checking most accurate descriptions)

Upper Extremity				Lower Extremity				
☐ Upper Arm	R	L	B	☐ Hip	R	L	B	
☐ Shoulder	R	L	B	☐ Thigh	R	L	B	☐ Head
☐ Clavicle	R	L	B	☐ Knee	R	L	B	
☐ Elbow	R	L	B	☐ Lower Leg	R	L	B	☐ Neck
☐ Forearm	R	L	B	☐ Ankle	R	L	B	
☐ Wrist	R	L	B	☐ Foot	R	L	B	☐ Pelvis
☐ Hand	R	L	B	☐ Great Toe	R	L	B	
☐ Index Finger	R	L	B	☐ 2nd Toe	R	L	B	☐ Spine
☐ Middle Finger	R	L	B	☐ 3rd Toe	R	L	B	
☐ Ring Finger	R	L	B	☐ 4th Toe	R	L	B	
☐ Small Finger	R	L	B	☐ 5th Toe	R	L	B	
☐ Thumb	R	L	B					

Location of Pain

Please indicate on drawing below where the pain/injury is located on your body



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What is the reason for today's visit? (Include Right or Left)_____

REVIEW OF SYMPTOMS:

Please circle all that apply:	Circle	If Yes Date	Please circle all that apply:	Circle	If Yes Date
Constitutional e.g. Fever, weight loss, malaise	YES NO		**Musculoskeletal** e.g. fracture, sprains, stiffness	YES NO	
Eyes e.g. Blurring, double vision, glasses	YES NO		**Skin/Breast** e.g. Rashes, lesions, scars, masses	YES NO	
Ear, Nose, Throat e.g. Deafness, sinusitis, vertigo	YES NO		**Neurological** e.g. Seizures, balance, memory, stroke	YES NO	
Cardiovascular e.g. chest pain, palpitations, high blood pressure	YES NO		**Psychiatric** e.g. Depression, sleep disturbance, hallucination	YES NO	
Respiratory e.g. Shortness of breath, cough, asthma	YES NO		**Endocrine** e.g. increased urinat ion, obesity, growth or hair changes	YES NO	
Gastrointestinal e.g. appetite, abdominal pain, constipation, weight change	YES NO		**Hematologic/Lymphatic** e.g. Bleeding tendency, anemia, lymph node pain or enlargement	YES NO	
Genitourinary e.g. Hesitancy, incontinence, pregnancies, menstrual problems	YES NO		**Allergic/Immunologic** e.g. Allergies, dermatitis, eczema	YES NO	

Pt. Height: _____ **Pt. Weight:** _____ **Lbs.**

Medical Conditions: _____

Previous Surgeries: _____

Current Medications: _____

Drug Allergies: _____

Family Medical History: _____

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

Patient Signature: _____ Date: _____

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Name: _____ Date: _____

If you would please take a moment to answer the following questions that we are now required by law to retrieve from you.

Language: ☐ English ☐ Other: _____

Ethnicity:
☐ Hispanic or Latino Not
☐ Hispanic
☐ Unknown

Race:
☐ American Indian
☐ Asian
☐ African American
☐ White
☐ Pacific Islander
☐ Other: _____

Smoker:
☐ Current Every Day
☐ Current Some Day
☐ Current Status Unknown
☐ Former Smoker
☐ Never Smoker
☐ Unknown if ever smoked

Did you have a drink containing alcohol in the past year?

☐ Yes ☐ No

If 'Yes': How often did you have a drink containing alcohol in the past year?

☐ Never ☐ 2 to 4 times a month ☐ 4 or more times a week
☐ Monthly or less ☐ 2 to 3 times a week

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 to 2 drinks ☐ 5 to 6 drinks ☐ 10 or more drinks
☐ 3 to 4 drinks ☐ 7 to 9 drinks

'If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Weekly
☐ Less than monthly ☐ Daily or Almost Daily
☐ Monthly

In the past year have you had :

☐ No falls ☐ Two or more falls with injury
☐ One fall without injury ☐ Two or more falls without injury ☐ One
fall with injury

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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: _____ Please enter your email address to allow us to contact you

Primary Care Physician: (Name, Address, Tel)_____ Age:_____

Pharmacy: (Name, Address, Tel)_____

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 ora car accident? ____ ***Yes*** ___ ***No***

If yes, pleasecircle one of thefollowing: Work Related Car Accident

INSURANCE INFORMATION

Health Insurance Carrier: _____ (Receptionist will copy your card)

Insured's Information if not the same as the patient:

Name: _____ D.O.B: _____ SS#: _____

Secondary Insurance Carrier: _____(Receptionist will copy your card)

Insured's Information if not the same as the

patient: Name: _____ D.O.B: _____ SS#: _____