116-16 Jamaica Ave
Richmond Hill, NY 11418
Tel # (718) 215-1888
Fax # (718) 215-1889

PRECISION PAIN CARE & REHABILITATION
Jeffrey Chacko, M.D.

AUTOMOBILE ACCIDENT PATIENT DEMOGRAPHIC FORM

1300 Union Tpke, Suite 203
New Hyde Park, NY 11040
Tel # (516) 419-4480
Fax # (516) 419-4481

PATIENT INFORMATION

DATE:____/____/_____ NAME:_____ _____
LAST FIRST M.I.

HEIGHT:_____ WEIGHT:_____ SEX: M / F MARITAL STATUS: _____

DATE OF BIRTH:____/____/_____ SOCIAL SECURITY #:_____

HOME ADDRESS:_____ APT #:_____

_____ _____ _____
CITY STATE ZIP CODE

CELL #:_____ HOME #:_____ WORK #:_____

EMAIL ADDRESS:_____

EMERGENCY CONTACT NAME:_____ PHONE #:_____

RELATIONSHIP TO PATIENT:_____

AUTOMOBILE ACCIDENT INFORMATION

INSURANCE CARRIER NAME:_____ DATE OF ACCIDENT:____/____/_____

POLICY #:_____ CLAIM #:_____

MAILING ADDRESS:_____

_____ _____ _____
CITY STATE ZIP CODE

ADJUSTER NAME:_____ TEL#:_____

LAWYER NAME:_____ TEL #:_____

ADDRESS:_____

_____ _____ _____
CITY STATE ZIP CODE

REFERRING PHYSICIAN:_____ SPECIALTY:_____

ADDRESS:_____ TEL #:_____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME:_____

INSURANCE ADDRESS:_____

_____ _____ _____ TEL #:_____
CITY STATE ZIP CODE

POLICYHOLDER NAME:_____ DATE OF BIRTH:____/____/_____

RELATIONSHIP TO PATIENT:_____ TEL #:_____

REFERRAL REQUIRED FROM PCP: YES☐ NO☐

AUTHORIZATION REQUIRED? YES☐ NO☐ UNSURE☐

ONSET OF SYMPTOMS

WHAT MEDICAL TREATMENT(S) HAVE YOU HAD SO FAR FOR THIS ACCIDENT? (CHECK ALL THAT APPLY)

- ☐ EMERGENCY ROOM CARE
- ☐ PRIMARY CARE PHYSICIAN
- ☐ X-RAYS
- ☐ EMG/NCV
- ☐ OTHER_____
- ☐ HOSPITAL
- ☐ CHIROPRACTOR
- ☐ MRI
- ☐ CAT SCAN
- ☐ MEDICATION

HAVE YOU HAD ANY PREVIOUS ACCIDENT(S)? YES☐ NO☐

IF YES, WHAT WAS THE APPROXIMATE DATE?____/____/_____

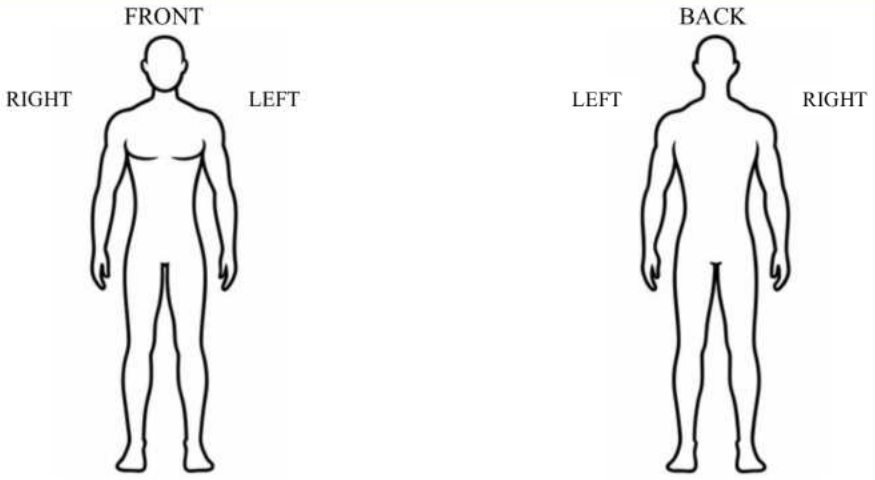
PATIENT HISTORY

CHIEF COMPLAINT (REASON FOR VISIT)_____

DOES THIS PAIN RADIATE? IF SO, WHERE?_____

PLEASE LIST ADDITIONAL AREAS OF PAIN_____

UISE THIS DIAGRAM TO INDICATE THE AREA OF YOUR PAIN. MARK THE LOCATION WITH AN "X"



PAIN DESCRIPTION

CHECK ALL OF THE FOLLOWING THAT DESCRIBE YOUR PAIN:

- ☐ DULL/ACHING
- ☐ HOT/BURNING
- ☐ SHOOTING
- ☐ STABBING/SHARP
- ☐ CRAMPING
- ☐ NUMBNESS
- ☐ SPASMING
- ☐ THROBBING
- ☐ SQUEEZING
- ☐ TINGLING/PINS AND NEEDLES
- ☐ TIGHTNESS

WHENS IS YOUR PAIN AT ITS WORST:

- ☐ MORNINGS
- ☐ DAYTIME
- ☐ EVENINGS
- ☐ MIDDLE OF THE NIGHT
- ☐ ALWAYS THE SAME

WHENS IS YOUR PAIN AT ITS WORST:

- ☐ CONSTANT
- ☐ CHANGES IN SEVERITY BUT ALWAYS PRESENT
- ☐ INTERMITTENT (COMES AND GOES)

RATE YOUR PAIN, IF "0" IS NO PAIN AND "10" IS THE WORST PAIN YOU COULD IMAGINE:

RIGHT NOW:_____ THE BEST IT GETS:_____ THE WORST IT GETS:_____

CURRENT MEDICATIONS

ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS OR ANTI-COAGULANTS? ☐ YES ☐ NO

IF YES, WHICH ONES? ☐ ASPIRIN ☐ PLAVIX ☐ COUMADIN ☐ LOVENOX ☐ OTHER_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING VITAMINS. PLEASE ATTACH ADDITIONAL SHEET IF NECESSARY:

	MEDICATION NAME	DOSE	FREQUENCY
1)			
2)			
3)			
4)			

ALLERGIES

DO YOU HAVE ANY DRUG/MEDICATION ALLERGIES? ☐ YES ☐ NO

IF YES, PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

	MEDICATION NAME	DOSE	FREQUENCY
1)			
2)			

TOPICAL ALLERGIES: ☐ LATEX ☐ IODINE ☐ TAPE ☐ IV CONTRAST

PAST MEDICAL HISTORY

MARK ALL APPROPRIATE DIAGNOSES:

☐ ARTHRITIS ☐ CANCER ☐ DIABETES

☐ HEADACHES/MIGRAINES ☐ HIGH BLOOD PRESSURE ☐ KIDNEY PROBLEMS

☐ LIVER PROBLEMS ☐ OSTEOPOROSIS ☐ RHEUMATOID ARTHRITIS

☐ SEIZURES ☐ STROKE ☐ HEART DISEASE

☐ FAMILY MEDICAL HISTORY (LIST ALL):_____

SOCIAL HISTORY

OCCUPATION:_____ DATE OF LAST TIME WORKED?____/____/_____

ALCOHOL USE: ☐ SOCIAL ☐ CURRENT ☐ DAILY ☐ NEVER ☐ HISTORY OF ALCOHOLISM

TOBACCO USE: ☐ CURRENT USER | PACKS PER DAY_____ ☐ NEVER USED

☐ FORMER USER | HOW MANY YEARS?_____ QUIT DATE:____/____/_____

PAST SURGICAL HISTORY

PLEASE LIST ANY SURGICAL PROCEDURES YOU HAVE HAD DONE IN THE PAST INCLUDING DATE:

1)_____ DATE:____/____/_____

2)_____ DATE:____/____/_____

☐ I HAVE **NEVER** HAD ANY SURGICAL PROCEDURES PERFORMED.

PRECISION PAIN CARE & REHABILITATION
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LIEN

ATTORNEY:_____ TEL #:_____

ADDRESS:_____

_____ _____ _____
CITY STATE ZIP CODE

I,_____hereby authorize this lien for and in consideration of the medical care given to and received by me from Precision Pain Care and Rehabilitation. I hereby assign transfer and set over unto Precision Pain Care and Rehabilitation such part of any amount that may hereafter become payable to me as a result of any settlement, claim, judgment, or verdict I may have against any insurance carrier, company, person or persons relating to the accident as may be equal to the amount of the charges for my care.

I fully understand that I am directly responsible for all medical equipment/supplies issued and medical bills owed to Precision Pain Care and Rehabilitation for services rendered to me and that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee or which is not covered by medical insurance. In the event the claims are dismissed or lost at trial, I agree to make full payment herewith within thirty(30) days.

I hereby authorize and direct my attorney(s) or any other persons whose hands or possession any of the process shall come, to hold in trust for and pay over to Precision Pain Care and Rehabilitation sums as claimed by Precision Pain Care and Rehabilitation for such medical care.

The attorney agrees to notify Precision Pain Care and Rehabilitation within seven (7) working days of the receipt of the proceeds from the above settlement or verdict regarding the patient. The attorney additionally agrees to pay the fore settled lien at the same time that the proceeds of the settlement or verdict are distributed to the patient.

In the event that any insurance policy exists which is responsible for payment of any of the services rendered by Precision Pain Care and Rehabilitation, the patient agrees to promptly apply for same benefits and surrender the payments thereof upon receipt to Precision Pain Care and Rehabilitation.

In the event that the attorney is substituted as counsel for the patient, the attorney and patient agree to notify incoming counsel of the existence of this lien and the terms thereof, and the patient agrees to be bound thereby.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

_____ _____
PATIENT NAME DATE OF ACCIDENT

_____ _____
ATTORNEY SIGNATURE DATE

If signed by anyone other than patient, print below:

Name:_____

Address:_____

Relationship to Patient:_____

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INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Precision Pain Care and Rehabilitation to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependents to my insurance carriers when necessary for the processing of insurance claims.

I hereby assign to Precision Pain Care and Rehabilitation all payments for medical services rendered to myself or my dependents. I understand that I am responsible for securing referrals from primary care physician and authorization from my insurance carriers when required for treatment. I further understand that payment due is not contingent on any settlement, judgment on any settlement or verdict by which I may eventually recover said fees.

_____ _____

PATIENT SIGNATURE DATE

_____

PATIENT NAME

If signed by anyone other than patient, print below:

Name:_____

Address:_____

Relationship to Patient:_____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I authorize Precision Pain Care and Rehabilitation to release my healthcare information to the below mentioned person.

NAME:_____

ADDRESS:_____

_____ _____ _____
CITY STATE ZIP CODE

PHONE #:_____

This request and authorization applies to:

Healthcare information relating to the treatment plan, diagnosis, medical records or dates of treatment.

Other (Specify):_____

PATIENT NAME:_____

DATE OF BIRTH:____/____/_____

_____ _____
PATIENT SIGNATURE DATE

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ **, ("Assignor") hereby assign to** _____ **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ **, not withstanding any other agreement**
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
Jeffrey Chacko, M.D.	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

PRECISION PAIN CARE & REHABILITATION
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GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.
I voluntarily request Dr. Jeffrey Chacko and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____	_____
PATIENT SIGNATURE	PRINT NAME	DATE
_____	_____	_____
WITNESS SIGNATURE	PRINT NAME	DATE
_____	Jeffrey Chacko, M.D.	_____
PHYSICIAN SIGNATURE	PRINT NAME	DATE

PRECISION PAIN CARE & REHABILITATION
PHYSICAL THERAPY
Jeffrey Chacko, M.D.
1300 Union Tpke, Suite 203 New Hyde Park, NY 11040
Tel # (516) 419-4480 Fax # (516) 419-4481

In agreeing to receive care provided by Precision Pain Care and Rehabilitation Physical Therapy, LLC, located at 1300 Union Turnpike, Suite 104, New Hyde Park NY 11040, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Precision Pain Care and Rehabilitation P.C. and the equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, soreness, strains, numbness, tingling, muscle tears, fractures, partial and/or total paralysis, death or other ailments, that could cause serious disability; (c) I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or conduct of the representatives or employees of Precision Pain Care and Rehabilitation P.C. or by any other person; and (d) I know that I have the right to choose what treatment I do or do not receive, in addition to withdrawing from treatment at any time; (e) I recognize that my participation in the activity covered hereby is conditional upon my signing and returning this waiver and release.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Precision Pain Care and Rehabilitation P.C. and its representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims that I may have presently or in the future for the negligent acts or conduct by the representatives or employees of Precision Pain Care and Rehabilitation P.C.

I understand that I may show this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY to, and consult with, my own independent legal counsel before signing.

Consent: I consent to and authorize Precision Pain Care and Rehabilitation P.C. (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING I AGREE. IT IS MY INTENTION TO EXEMPT PRECISION PAIN CARE AND REHABILITATION P.C. FROM LIABILITY FOR PERSONAL INJURY.

_____	_____	_____
PATIENT SIGNATURE	PRINT NAME	DATE

PRECISION PAIN CARE & REHABILITATION
PHYSICAL THERAPY
Jeffrey Chacko, M.D.
1300 Union Tpke, Suite 203 New Hyde Park, NY 11040
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NEW PATIENT ACKNOWLEDGEMENTS

Consent to Treatment

_____ (Initial) I consent to and authorize Precision Pain Care Rehabilitation and Physical Therapy to administer rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

Notice of Privacy Practices

_____ (Initial) I hereby acknowledge that I have been made aware of Precision Pain Care and Rehabilitation's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the front desk and online, and that I may request a copy of any amended Notice of Privacy Practices at any time.

Authorization to Release / Obtain Information

_____ (Initial) I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Precision pain care and rehabilitation to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone and/or facsimile.

Insurance Eligibility

_____ (Initial) Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

Financial Responsibility

_____ (Initial) Payment is due at the time of treatment. I agree to pay Precision Pain Care and Rehabilitation all amounts that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney’s fees.

Assignment & Release of Benefits

_____ (Initial) I hereby appoint Precision Pain Care and Rehabilitation as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my “Plan”), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan. I also authorize PPC ("Precision Pain Care and Rehabilitation") to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to PPC and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to PPC not later than ten (10) days after my receipt.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE <u>BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT</u>. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: _____	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)	13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:
FROM: _____ THROUGH: _____	_____ (DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES ☐ NO ☐ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	☑ INDEPENDENT CONTRACTOR	OTHER (SPECIFY)
Jeffrey Chacko, M.D.	M.D.	256586			

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____

PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR

PRINT NAME _____ SIGNED _____ DATE
PATIENT (Assignor) PATIENT

PRINT NAME Jeffrey Chacko, M.D. SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY
		47-2126819	CPMR

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME BUSINESS	
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE	

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

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12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____

AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

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THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representatitve authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

PRECISION PAIN CARE & REHABILITATION
Jeffrey Chacko, M.D.

116-16 Jamaica Ave
Richmond Hill, NY 11418
Tel # (718) 215-1888
Fax # (718) 215-1889

1300 Union Tpke, Suite 203
New Hyde Park, NY 11040
Tel # (516) 419-4480
Fax # (516) 419-4481

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED ANDHOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operatlons (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mentalhealth or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physiclan's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected heaith information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activitles include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activitles. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you willbe asked to sign your name and indicate your physician. We may also callyou by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Willbe made only with your consent, authorization or opportunity to Object unless required by law.

You may revoke this authorization, at any time, except to the extent that your physiclan or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

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HIPAA NOTICE OF PRIVACY PRACTICES (CONT.)

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. **We will not retaliate against you for filing acomplaint**.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please as to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

_____ _____ _____

PATIENT SIGNATURE PATIENT NAME DATE

- ☐ I authorize the doctor and staff members to leave messages on my home/cell/work answering machine for purposes such as: appointments and billing questions.
- ☐ I prefer to be reached at the following phone number _____-_____-_____, instead of my home phone number.
- ☐ I authorize the doctor and staff members to discuss my protected health information with the following people:

Name:_____ Phone#:_____-_____-_____ Relationship_____

Name:_____ Phone#:_____-_____-_____ Relationship_____

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AGREEMENT FOR NARCOTIC PRESCRIPTIONS

PATIENT NAME_____ **DOB**____/____/_____

Sometimes during the treatment of patients we find it necessary to prescribe medications including Narcotics. In an effort to monitor and manage NARCOTIC prescripts we have outlined our clinic policy below:

1. All Narcotic Medications must be filled at the pharmacy:

_____ _____

PHARMACY NAME PHONE NUMBER

2. Evidence of stockpiling will not be tolerated. Escalation of your medication dose will not be tolerated.
3. Obtaining narcotics from other providers will not be tolerated. This includes dentists and the emergency room etc. If the patient is having surgery or needing meds for another reason YOU MUST notify our office. Failure to do so may result in discharge from the clinic. You can leave a message if it is afterhours.
4. Patients will need to be seen on a regular basis to continue prescription refills as determined by their provider. If a patient fails to follow-up regularly or misses appointments medication refills will not be permitted.
5. l agree to submit to random Urinalysis. A urinalysis is when a sample of my urine is checked to see what drugs I have been taking and how my body is metabolizing those drugs.
6. Your provider may taper and discontinue the narcotic prescription if they feel no benefit is being obtained from it.
7. No narcotic refills will be given on evenings, weekends or holidays. The patient must plan accordingly. **OUR REFILL POLICY IS 48 HOUR NOTICE**.
8. Narcotics are the responsibility of the patient. The provider will not replace lost or stolen prescriptions.
9. Other providers in the office are not obligated to refill medications if your provider is not available.
10. Patients understand that narcotic medications may cause difficulty or alteration in judgment and they should not operate heavy machinery or a motor vehicle.
11. All patients must read and sign this contract. If a patient is found to be in violation of the above stated rules, the patient may be discharged from this office with no further medication refills.
12. To continue to have prescription refills, patient must be compliant with all phases of the treatment plan outlined by the provider.
13. I agree to take the narcotics exactly as instructed by the prescribing provider.
14. I agree to thefollowing:

    a. That l am NOT currently abusing illicit or prescription drugs and that I am not undergoing treatment for substance dependence or abuse.
    b. That I have never been involved in the sale, illegal possession, or transport of any drugs.
    c. For women only: That I am not pregnant and that I will inform the physician ifl become pregnant.

I have read and understand the above statement and will comply.

Patient Signature_____ Print Name_____ Date____/____/_____

Witness Signature_____ Print Name_____ Date____/____/_____

Precision Pain Care & Rehabilitation

Jeffrey Chacko, M.D.

1300 Union Tpke, Suite 104
New Hyde Park, NY 11040
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CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or the patient named below, for whom I am legally responsible) by Dr. Jeffrey Chacko and/or other licensed acupuncturist at Precision Pain Care and Rehabilitation.

I understand that methods or treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, Chinese massage, Chinese or western herbal medicine, and nutritional counseling. I have had the opportunity to discuss with the Physician and/or acupuncturist the nature and purpose of acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. I have also been informed that there have been very rare instances reported of fainting, infections, scarring and burning from heat lamps. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. I understand the aforementioned risks and benefits of acupuncture. The risks include but are not limited to the above.

Electroacupuncture may be used for treatment. Published reports suggest that electroacupuncture should not be used in patients who have a pacemaker or defibrillator, since there is a theoretical risk of malfunction. By signing this form, I acknowledge and understand that electroacupuncture is not recommended to be performed if I have a pacemaker or defibrillator, and that I have disclosed if I have a pacemaker or defibrillator to the licensed acupuncturist performing my treatment. I understand the risks of not disclosing this information to the acupuncturist. The risks include but are not limited to the above.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, and is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent.

By signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient	Print Name	Date
Witness Signature	Print Name	Date
Acupuncturist Signature	Mengrong Li Print Name	Date
Physician Signature	Jeffrey Chacko, M.D. Print Name	Date