

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

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

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

PATIENT DEMOGRAPHIC FORM

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: _____

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT US? FRIEND ☐ INTERNET ☐ SIGN ☐ AD ☐ INSURANCE ☐

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____ **TEL #:** _____

ADDRESS: _____

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE:** _____

PATIENT HISTORY

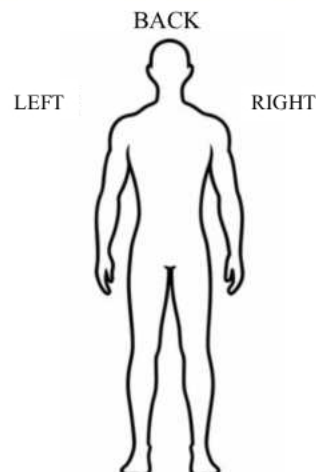
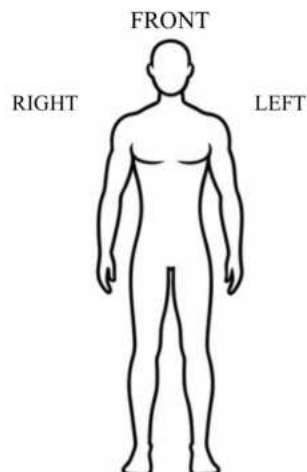
CHIEF COMPLAINT (REASON FOR VISIT) _____

DOES THIS PAIN RADIATE? IF SO, WHERE? _____

PLEASE LIST ADDITIONAL AREAS OF PAIN _____

WHEN DID THE PAIN START? _____

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



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:

<u>MEDICATION NAME</u>	<u>DOSE</u>	<u>FREQUENCY</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

ALLERGIES

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

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

<u>MEDICATION NAME</u>	<u>DOSE</u>	<u>FREQUENCY</u>
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.

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INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS

All co-payments are due to Precision Pain Care and Rehabilitation at the time of service. Patient agrees to pay all deductibles, coinsurance, and services deemed patient responsibility as identified by the insurance carrier. Deductibles, coinsurance, and patient portions are billed monthly on receipt of the patients' insurance statement from the insurance carrier regarding your patient claim. **YOU**, the patient, are responsible to render payment once billed for the remainder. Patients are fully responsible for obtaining any necessary referral from another physician before the appointment time. Claim payments denied due to lack of referral become the patient's responsibility. Although we make every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim. The insurance carrier makes final determination, based upon the plan's level of coverage and associated policies, upon receiving the claim. Denied claims become the responsibility of the patient.

I have read the above information and agree to the terms contained therein

_____ **Initial**

Patient's Signature:

Patient's PRINTED Name:

Social Security #:

Date:

SELF PAY PATIENT FINANCIAL LIABILITY FORM
--

Please understand that full payment of your account/bill is paid directly to Precision Pain Care and Rehabilitation and considered part of your treatment and is required for all services rendered. Also, understand that payment of past services rendered and treatment given is required before all future services and treatment may be made. We expect full payments at the time services are rendered. This office accepts Visa, Mastercard, or cash with a valid photo ID. Extended payment plans may be offered with PRIOR credit approval and PRIOR patient request. All unpaid accounts are sent to collection after payment is not made in a reasonable time period and may adversely affect your credit. Non-emergent medical services can be denied for unpaid accounts.

I have read the above information and agree to the terms contained therein

_____ **Initial**

Patient's Signature:

Patient's PRINTED Name:

Social Security #:

Date:

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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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APPEAL REQUEST FORM FOR DENIAL OF SERVICES

ENROLLEE INFORMATION

NAME: _____

DOB: ____/____/____

ENROLLEE ID: _____

PLAN REFERENCE NUMBER: _____

SERVICE BEING DENIED: _____

TYPE OF APPEAL REQUEST: Provider requesting appeal of denial on behalf of member

Requester (Person asking for me):

Jeffrey Chacko, =M.D.
Medical Director
Precision Pain Care & Rehabilitation
Phone: (516) 419-4480
Fax: (516) 419-4481

ENROLLEE SIGNATURE: _____ **DATE:** ____/____/____

REQUESTER SIGNATURE: _____ **DATE:** ____/____/____

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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

PHYSICIAN SIGNATURE

Jeffrey Chacko, M.D.

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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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

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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: _____

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

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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.

**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 representative 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.

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW 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 operations (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 mental health 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 physician'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 health 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 activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. 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 will be asked to sign your name and indicate your physician. We may also call you 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: Will be 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 physician 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 a complaint.**

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 _____

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

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

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

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. I 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 the following:
 - a. That I 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 if I 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

1300 Union Tpke, Suite 104
New Hyde Park, NY 11040
Tel# (516) 544-3455
Fax# (516) 544-0196

Jeffrey Chacko, M.D.

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

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

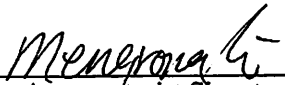
Print Name

Date

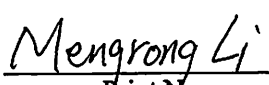
Witness Signature

Print Name

Date

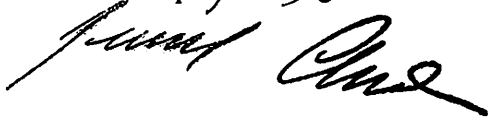


Acupuncturist Signature



Print Name

Date



Physician Signature

Jeffrey Chacko, M.D.

Print Name

Date