HOSPITAL FOR SPECIAL SURGERY
Stephen Massimi, MD
SPINE AND HIP SPECIALIST
PHYSIATRY, SPORTS MEDICINE
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TEL 203-705-2350 FAX 203-705-2924

AUTHORIZATION FOR TREATMENT, HIPAA PRIVACY POLICY, ASSIGNMENT OF BENEFITS, FINANCIAL POLICY, RELEASE OF INFORMATION, ELECTRONIC COMMUNICATION, OFFICE POLICY

The Office of Dr. Stephen Massimi (Stephen Massimi MD PC) is committed to providing you with the highest level of care. In our ongoing process to make sure that all your medical needs are met, our staff is available to discuss our privacy practices, fees, and this policy with you. Please review this form carefully. It describes the practices of our office and requests authorization from you to help deliver your care, share your information securely, and bill appropriately.

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Stephen Massimi MD PC and Hospital for Special Surgery, its medical practices and providers including Dr. Stephen Massimi, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures. I understand that Dr. Stephen Massimi is available to explain all treatments and I have the right to refuse treatment.

PRIVACY NOTICE: 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 health information. In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have our HIPAA Notice of Privacy Practices on display in the reception area and a printed copy of the HIPAA notice will be provided upon request. If you have any objections to this form, please ask to speak with us in person or at our main phone number as listed on this form. By signing this form, I acknowledge that I have received and understand the Health Information Privacy Notice for Stephen Massimi MD PC and Hospital for Special Surgery, which is also available online at https://www.hss.edu/notice-of-privacy-practices.asp. I understand as part of my health care, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for further case or treatment.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF MEDICAL BENEFITS: I request that payment of authorized medical benefits is made on my behalf directly to Stephen Massimi MD PC. I authorize Stephen Massimi MD PC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Stephen Massimi MD PC. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered. I further understand and agree to pay for the services or amounts due when appropriate. These charges could include amounts applied to my annual deductible, co-payment amounts, and charges denied as not covered by my insurance program or deemed medically necessary. I acknowledge that a copy of this authorization shall be considered valid.

REFERRAL: I understand that if my insurance requires a referral from my primary care provider for specialist services and if I do not have the referral at the time of the appointment, and I still choose to receive the services without the required referral, then it will be my responsibility to contact my primary care provider's office the same day and obtain the necessary referral, dated for the date of the service. I also accept full financial responsibility for all charges

incurred for services received on the day of service if my insurance carrier denies the claim(s) for lack of and/or invalid referral.

NON-COVERED SERVICES: I am aware that some of the services I may receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. An example is a platelet-rich-plasma (PRP) injection. Payment for these services must be paid at the time of the visit.

PAYMENT: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through Stephen Massimi MD PC from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a Stephen Massimi MD PC billing statement whether it is an interim or final bill. Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, and American Express. As a courtesy to you, it is the policy of Stephen Massimi MD PC to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.

2. It is your responsibility to know and understand your own insurance program. It is your responsibility to know the amount of your insurance deductible. It is your responsibility to know whether this office is participating with your particular insurance plan and program. It is your responsibility to know if you need a referral or pre-authorization for today, future visits, procedures, or tests. It is your responsibility to advise this office of your programs requirements in advance, each and every time we provide a service. We will do our very best to comply with any reasonable requirements that your program may have.

3. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees. Additional fees may apply to the following: returned checks, completion of disability or other forms, and copying of medical records.

4. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Stephen Massimi MD PC, you recognize an obligation to promptly remit payment to Stephen Massimi MD PC.

5. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, then appropriate collection measures may be initiated. I also understand that after such default and upon referral to a collection agency or attorney by Stephen Massimi MD PC, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The office of Stephen Massimi MD PC understands that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call us at 203-705-2350.

MISSED APPOINTMENTS: We ask that you provide us the courtesy of 24 hours (1 business day) notice for the cancellation of office visits, and 48 hours (2 business days) notice for the cancellation of procedures so that we can fill

in those appointment slots with other patients who may be waiting. If you miss your appointment, or do not cancel with the required notice, then additional fees may apply.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality, and to coordinate patient care across the provider network, avoiding duplication of services. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient medical records are automatically sent to referring providers and primary/family physicians, as well as to physicians who are consulted by the attending physician for coordination of care. Stephen Massimi MD PC may furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

ELECTRONIC PRESCRIBING: I understand that Stephen Massimi MD PC may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my Stephen Massimi MD PC and my pharmacy. I have been informed and understand that Stephen Massimi MD PC will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to Stephen Massimi MD PC to see this health information.

CONSENT FOR ELECTRONIC COMMUNICATION: I authorize Stephen Massimi MD PC, including Dr. Stephen Massimi and assigned office staff, to contact me at the phone numbers I have provided to the office, as well as to leave messages on my voicemail or answering system. This includes messages related to upcoming appointments, notification to call us back regarding test results or other medical issues, and for billing purposes. As a service to our patients, we provide a courtesy Bill Pay Reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your phone number, you consent to receiving such calls at this number. You also agree to receive SMS messages from our office for the purpose of obtaining feedback on your satisfaction with our care. You will be prompted to opt-out of such messages if desired.

LITIGATION: It is understood and agreed that I am requesting care and treatment for medical purposes only and not in connection with pending or proposed litigation. It is further understood and agreed that Dr. Stephen Massimi will not participate in any litigation that may arise, except to provide a true, accurate, and complete copy of all medical records and diagnostic studies in the possession and control of this office pursuant to a HIPAA compliant authorization.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

_____

Patient name

_____ _____

Signature of Patient or Parent/Legal Guardian/Authorized Representative Date

_____

Relationship to Patient (if applicable)

New Patient Questionnaire

Stephen Massimi, MD

HOSPITAL FOR SPECIAL SURGERY

Name: _____ Appointment Date: _____ Age: _____

Sex: ❑ Male ❑ Female Height: ____ft ____in Weight: _____lbs

Referred by: _____ Tel: _____

What is the name of your primary physician? _____, MD Tel:_____

What pharmacy do you use? _____ City: _____ Tel:_____

Chief complaint / problem: ❑ RIGHT ❑ LEFT _____

On what date did you first notice your symptoms? (approximate if unknown) _____

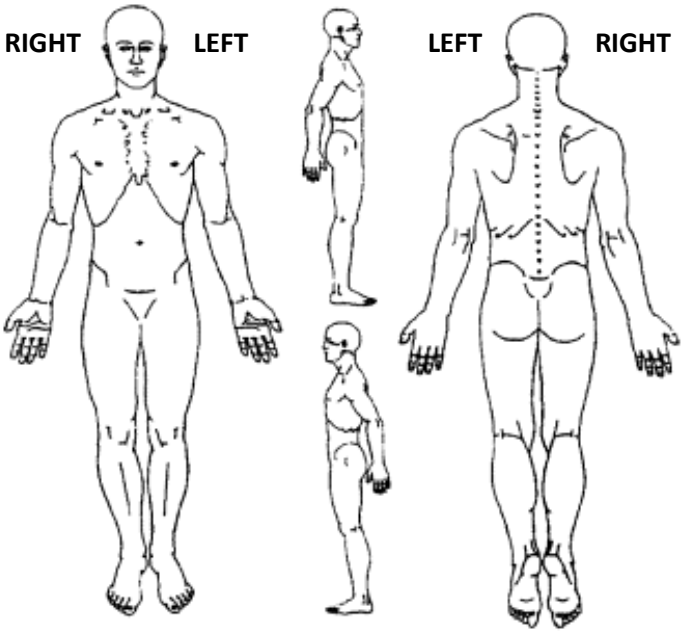
Are your symptoms the result of: ❑ Injury - if so, please indicate: ❑ Accident ❑ Sport ❑ Auto ❑ Work ❑ Other

❑ No injury

If any incident or event prompted your symptoms, please describe here: _____

_____

Please indicate below where your symptoms are located:



Describe the quality of your pain: ❑ Achy ❑ Sharp ❑ Burning ❑ Dull ❑ Throbbing ❑ Stabbing

The pain is: ❑ Constant ❑ Comes and goes (intermittent)

Indicate if you have any:

❑ Numbness ❑ Tingling ❑ Weakness ❑ Fevers ❑ Chills ❑ Bruises/Rashes ❑ Impaired balance ❑ Difficulty controlling your bowel or bladder ❑ Locking or Catching ❑ Giving way ❑ Swelling

Since my problem started, it is getting:

❑ Better ❑ Worse ❑ Unchanged

Does the pain wake you from sleep?

❑ No ❑ Yes

Rate the intensity of your symptoms from 0 to 10 below.

Circle when it is at its **BEST** and **WORST**:

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										WORST PAIN EVER

What makes your symptoms worse? _____

Check all that apply: ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down ❑ Exercise ❑ Lifting ❑ Bending ❑ Twisting ❑ Squatting ❑ Kneeling ❑ Stairs ❑ Coughing ❑ Sneezing

What makes your symptoms better? _____

Check all that apply: ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down ❑ Exercise ❑ Rest ❑ Ice ❑ Heat ❑ Elevation

Have you had or tried any of the following treatments for this condition (please select and describe)?

Type	Date Range	Location/Results	Effective?
Medication:			Yes No
Medication:			Yes No
Injection (what kind?):			Yes No
Injection (what kind?):			Yes No
Physical Therapy			Yes No
Surgery			Yes No
Other:			

Have you had any of the following tests for this condition?

Type	Date	Results
X-Ray		
MRI		
CT Scan		
Other:		

Immunizations and Falls Screening

Have you received the pneumonia vaccine? Yes No

If yes, date?_____ If not, why?_____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No

If yes, date?_____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Allergies and Medications

Please list any allergies and reactions if known:

Allergy	Reaction
1.	
2.	
3.	

Please list your current medications (including vitamins and supplements):

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medical History

Please list your past or current medical conditions below (even if controlled, e.g. high blood pressure):

_____

_____

_____

Family History

Please list any medical conditions of your family members (mother, father, etc.)

_____

_____

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Social History

Are you a tobacco user? Yes No

If yes, how many packs per day? _____

Do you consume alcohol? Yes No

If yes, how many drinks per week? _____

Do you use any recreational drugs? Yes No

If yes, what kind(s): _____

What is your dominant hand? Left Right Ambidextrous

Are you currently working? Yes No

If yes, what profession: _____

What is your marital status? _____

Do you have any children? Yes No

If yes, how many: _____

Are you physically active? Yes No

If yes, what activities/sports: _____

Review of Systems

Do you currently have, or have you had any of the following in the past year *(select all that apply for each section):*

Constitutional	Hematological	Respiratory	Skin
Vomiting	Adenopathy	Chronic Cough	Discoloration
Chills	Easy Bruising/Bleeding	Shortness of Breath	Bruising
Nausea	DVT	Wheezing	Non Wound Healing
Fever	Anemia	Difficulty Breathing	Rash
Sleep Difficulty			
Fatigue			
None	None	None	None

HEENT	Cardiovascular	Endocrine/Hormonal	Musculoskeletal
Double Vision	Chest Pain	Intolerance of Cold	Decreased ROM
Headaches	Edema	Intolerance of Heat	Joint Redness
Hearing Loss	Palpitations	Weight Loss	Muscle Pain
Hoarseness		Weight Gain	Joint Swelling
Runny Nose		Hair Changes	Muscle Cramps
		Nail Changes	Muscle Weakness
			Leg Cramps
			Joint Stiffness
None	None	None	None

Gastrointestinal	Genitourinary	Neurological	Psychiatric
Abdominal Pain	Bladder Incontinence	Paralysis	Depression
Bowel Habits Change	Urinary Retention	Dizziness	Anxiety
Trouble Swallowing	Irregular Menses	Weakness	Memory Loss
Heartburn/GERD	Non-menstrual Bleeding	Loss of Balance	Substance Abuse
	Pelvic Pain	Numbness	Suicidal Ideas
	Urinary Urgency	Paresthesias	
	Urinary Leakage	Seizures	
	Erectile Dysfunction	Difficulty Walking	
	Decreased Libido		
	Retrograde Ejaculation		
None	None	None	None

Please list any questions/goals you have for this visit: