ELEVATED
HEALTH NYC

Welcome to Elevated Health NYC, the leading specialists in Federal Workers' Compensation injuries in NYC, and we are here to help you with all of your work-related injuries. Please understand that any chronic health problems are best addressed by your primary care provider, so our clinicians will not be providing treatment for chronic conditions **EXCEPT** musculoskeletal-related conditions during the exam. In keeping with these standards and to promote continuity of care, it is very important for us to know your medical history. Please complete all of the below information **prior to arriving** for your appointment. Exams may need to be rescheduled for patients who do not complete all of the following forms.

Personal Information:

First Name: _____ Last Name: _____

DOB: ____/____/_____ Age: _____ Last 4 of SSN:_____

(Used to keep track of case once it's been filed)

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Number:_____ Email Address: _____

Occupation: _____ Employer: _____

Referral Source: _____

Insurance Information:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in getting my case accepted and in turn collecting payment from the Department of Labor. However, in the event that my case is not accepted, I understand that this office will attempt to bill my private insurance company and any amount authorized will be paid directly to this Office, and will be credited to my account upon receipt. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, or ignore requests to submit the necessary paperwork to pursue my case, any fees for professional services rendered to me will be immediately due and payable.**

Patient's Signature: _____ Date: _____

Please provide Insurance Info:

☐ Aetna ☐ BCBS ☐ Cigna ☐ GHI ☐ Oxford ☐ UHC ☐ None ☐ Other:

_____

ID#_____

Policy #: _____

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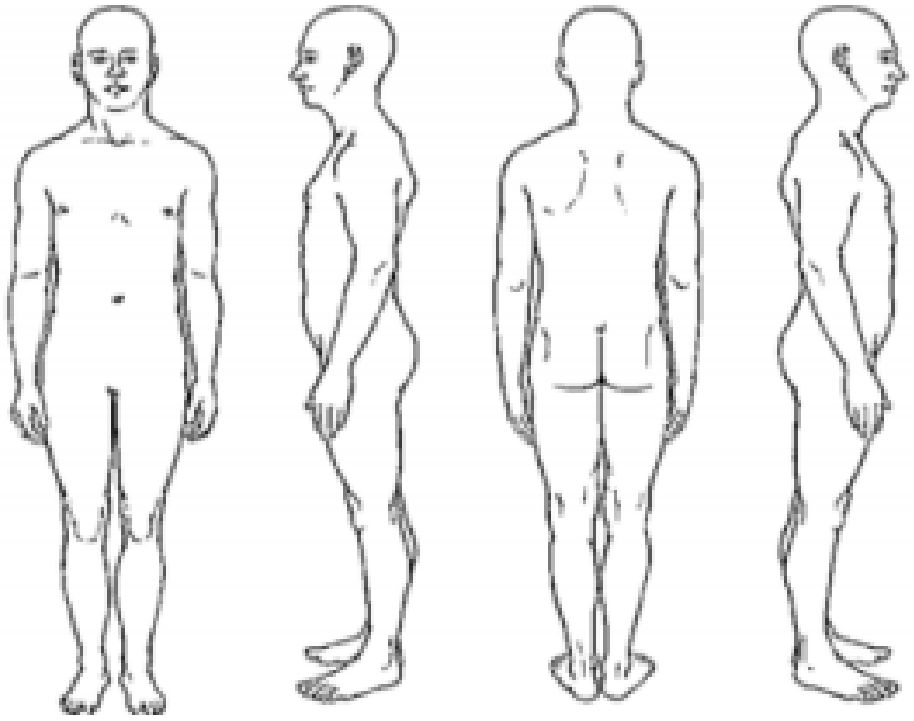
PAIN DRAWING

Using the descriptive symbols, draw the location of your pain on the body outline below:

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^^	======	oooooo	.....	//////	xxxxx



Please make a slash through the below line as to the level of your pain:

NO PAIN **WORST POSSIBLE PAIN**

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MEDICAL HISTORY

Check if you currently have or have had any of the following ✓

Asthma		Allergies		Abdominal Disorders		Arthritis	
Alcohol Abuse		Blood Disorder (Clots, Bleeding tendency)		Cancer		Cardiac Issues	
Drug Abuse		Diabetes		Dental Disease		Emphysema	
Eye Disease		Gallbladder Disease		Glaucoma		Gastrointestinal Disorder (Acid Reflux, Hemorrhoids, Ulcer)	
Gynecological Disorder		Heart Disease		Hearing Defect		Hepatitis	
High Blood Pressure		High Cholesterol		Kidney Disorder		Liver Disease	
Mental Illness (Anxiety, Depression, Eating Disorder)		Muscular Disease		Neurological Issues (Migraines, Seizure, Stroke)		Nervous System Disorder	
Obstructive Pulmonary Disease		Prostate Disease		Rheumatic Disease		Skin Disorder	
Sleep Disorders (Apnea, Narcolepsy)		Sexually Trasnmitted Disease		Thyroid Disorder		Tuberculosis	
Ulcer		Vein Disorder (Varicose)		Other:			

Please explain any of the above that you checked off:

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MEDICAL HISTORY QUESTIONNAIRE

SURGERIES: List any surgeries including specific dates or age at time of surgery:
HOSPITALIZATIONS: List any hospitalizations, including dates of and reasons for hospitalization:
MEDICATIONS: List any prescription medications (w/ dosage and frequency of use) you are now taking:
List any self-prescribed medications, dietary supplements, or vitamins (w/ dosage and frequency of use) you are now taking:
ALLERGIES: List any drug or medical materials (i.e. latex) allergies and reaction:

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REVIEW OF SYMPTOMS

Check if you currently have or have had any of the following ✓

Abdominal Pain		Abnormal Stool		Back Pain		Blood in Urine	
Blurred Vision		Chest Pain		Change in Bowel Habits		Change in Size/Color of Mole	
Coughing up Blood		Constipation		Difficulty Sleeping		Difficulty Swallowing	
Dizziness		Diarrhea		Eye Pain		Ear Pain	
Fainting		Fatigue		Fevers		Frequent Cough	
Headache		Hearing Loss		Hoarse Voice		Inability to Sleep Flat	
Indigestion		Joint Pain (list)		Lightheadedness		Loss of Appetite	
Mood Changes		Muscle Cramps		Muscle Weakness		Nausea	
Neck Pain		Night Sweats		Nosebleeds		Numb/Tingling	
Palpitations		Persistent Bruising		Rash		Ringing in Ears	
Rectal Pain		Sexual Dysfunction		Shortness of Breath		Skin Color Changes	
Sore Throat		Stress		Swollen Glands		Swollen Joints	
Tremors		Urine Infection		Weight Gain/Loss		Wheezing	
Vomiting		Other:					

Additional Comments:

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INJURY QUESTIONNAIRE

For **Traumatic** Injuries (CA1), answer Question **1 ONLY.**
For **Repetitive** Conditions (CA2), answer Questions **1 AND 2.**

1. **PATIENT STATEMENT:** Describe with as much detail as possible the employment-related activities which you believe contributed to your injury/condition.
2. When did you first notice this condition? Has it come and gone, or has it been present continuously? What symptoms have you experienced?
3. Have you sought out medical attention for this injured body part in the past? If yes, when?
4. Do you have any other jobs or hobbies that could have contributed to this injury?

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PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Elevated Health NYC to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Elevated Health NYC Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Rock Professional offices reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Elevated Health NYC
315 Madison Avenue, Suite 801
New York, NY 10017

With this consent form, Elevated Health NYC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results, among others.

With this consent form, Elevated Health NYC may mail to my home or other alternative location any items that assist in carrying out treatment, payment, or healthcare operations such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With this consent form, Elevated Health NYC may email to my home or other alternative location at any time to assist the practice in carrying out treatment, payments, or healthcare operations such as appointment reminders. I have the right to request that Elevated Health NYC restrict how it uses or discloses my PHI to carry out treatments, payments and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Elevated Health NYC use and disclosure of PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Elevated Health NYC may decline to provide treatment to me.

_____ _____
Patient Name Date

_____
Signature of the Patient or Legal Guardian

_____
Print Name of Legal Guardian (if applicable)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the **Health Insurance Privacy & Accountability Act of 1996 (HIPAA**) I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have reviewed your **Notice of Privacy Practice** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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FEDERAL INJURY CENTER PATIENT AGREEMENT

As a Federal Injury Center, our entire staff at Elevated Health is dedicated to helping you get your work-related injury treated and you back to work as soon as possible. There are certain things that we can take care of for you on our end, and certain things that you will have to take care of on your end, in order to get your case approved in a timely manner.

Please review and initial the following statements to show your understanding of our Patient Policies:

_____I understand I am required to provide this office ALL documentation whether sent to my agency by me or my representative or received from my agency irrespective of whether I believe it to be important or not so it may be reviewed for action items and added to my file.

_____I understand I am required to provide this office ALL documentation whether sent to OWCP by me or my representative or received from OWCP irrespective of whether I believe it to be important or not so it may be reviewed for action items and added to my file.

_____I understand my treatment may be terminated, paused or postponed should I not provide all documentation required of me for the acceptance of my case. I will promptly respond to any and all inquiries from my agency and OWCP.

_____I understand this office bills OWCP directly for my care after the claim has been approved by OWCP. The issuing of a claim number does not mean or indicate your claim has been accepted by OWCP. Should I not provide documentation to this office which is required for approval (employee statements/narrative, factual data, information requests, imaging and diagnostic information, denial letters, reconsideration request forms, appeal forms etc.) or timely processing of my claim that **I will be personally liable for any and all fees associated with my care.** I understand I simply need to provide all requested documentation or information in order to not be personally liable for any and all fees.

_____I understand it is my responsibility to call OWCP to verify the receipt of documentation, case status updates and at the request of the staff.

_____I understand that while this office will help in assisting me with my claim and provide claim management i**t is ultimately my responsibility to provide my agency and OWCP with requested information and documentation.** I will provide my agency with all CA-17 Duty Status Reports and all supporting documentation when submitting claims for compensation by use of form CA-7 and CA-7a. I further understand that all information provided to me as claim management is not legal advice and does not replace the advice of an attorney.

Please sign below to indicate that you have read the above and agree to our office policies:

Print Name: _____ Signature: _____ Date: _____

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PATIENT APPOINTMENT POLICY AGREEMENT

As a Federal Injury Center, our entire staff at Elevated Health is dedicated to helping you get your work-related injury treated and your case approved. In order for us to assist you with these efforts, we need you to attend all of your scheduled appointments in a timely manner.

Please review and initial the following statements to show your understanding of our Patient Appointment Policies:

_____I understand that missing appointments will impact my case negatively, and therefore, I will attempt to attend all my appointments at their scheduled time.

_____I understand that I am required to arrive for my **FIRST appointment 30 minutes prior to my scheduled time.** This time is to compensate for any initial paperwork that needs to be completed at the time of my visit.

_____ I understand that if I am **more than 30 minutes late** to any of my scheduled appointments, the office has the right to reschedule my appointment for another day/time.

_____ If I can no longer make a scheduled appointment, **I will call the office at least 24 hours in advance of my appointment** in order to reschedule at the next available time.

_____ I understand that if I **cancel within 24 hours** OR **do not show up for my appointment without notice** a maximum of **3 times,** my future services at Elevated Health NYC may be terminated indefinitely.

_____I completely understand the above and have asked any questions needed for clarification prior to signing this form.

Please sign below to indicate that you have read the above and agree to our office policies:

Print Name: _____ Signature: _____ Date: _____
PATIENT

Print Name: _____ Signature: _____ Date: _____
PROVIDER