Patrick F. O'Leary, M.D., F.A.C.S., P.C.
Spinal Surgery
1015 Madison Avenue
New York, NY 10075

Date: _____

Name (Print)_____ Age: ____ Birthdate: _____

Home Address _____ Phone (_____) _____

City _____ State _____ Zip Code _____

Employer _____ Phone (_____)_____

Address _____

Marital Status _____ Occupation _____

Spouse's Name _____ Occupation _____

Employer _____ Phone (_____)_____

Name & Address of person to be billed _____

_____

Copy of Office Report to _____

Address _____

Family Doctor _____

Address _____

Referring Doctor or Person_____Phone(_____)_____

Address _____

List in Order of Importance Your Main Complaints:

1: _____

2: _____

3: _____

Others _____

When Did Problem Start? _____

How? _____

_____

Getting Better _____ Getting Worse _____ No Changes/Same _____

Please Complete Next Page

Please provide a written history of your present problem:

_____

_____

_____

_____

Detail your Treatments to Date in Chronological Order:

_____

_____

_____

_____

_____

PAST HISTORY

Operations and Dates of Surgery: _____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please note any complains with reference to your:

Head _____ Heart/Lungs _____ Kidneys _____

Neck _____ Appetite _____ Urine _____

Eyes _____ Bowels _____ Stomach _____

Ears, Nose, Throat _____

Medical Illnesses _____

Family Illnesses, Parents, etc. _____

Type of Work & Recreation _____

Do you smoke ? _____ If Yes, how much _____

Do you drink ? _____ If Yes, how much _____

Female: Date of Last Menstrual Period _____ Date of Menopause _____

Any problems with your:

Hips _____ Knees _____ Ankles _____

Shoulders _____ Elbows _____ Wrists _____

Circle Tests done: X-Rays MRI CT EMG BONESCAN OTHER _____

Pharmacy Name Phone: Address:

Medication Name: Dosage: Condition used for: Prescribing Physician:

Allergic to any Medication? _____

Do you have any other allergies?

Disability: If you have been incapacitated and unable to work, please give dates of disability

From _____ To _____

Please list Insurance Coverage:

1. Primary Insurance Carrier : _____

Address: _____

Telephone (_____)_____ Cardholder Name _____

Identification #: _____ Group #: _____

2. Secondary Insurance Carrier :_____

Address: _____

Telephone (_____)_____ Cardholder Name _____

Identification #: _____ Group #: _____

3. Other Insurance Carrier :_____

Address: _____

Telephone (_____)_____ Cardholder Name _____

Identification #: _____ Group #: _____

Social Security # _____ Medicare # : _____

We require payment upon completion of visit and presentation of bills. It is the responsibility of the patient to pay their bill, and to submit their paid bills to the insurance company for reimbursement.

Signature _____ Date _____

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MEDICATION LOG

PATIENT INFORMATION			
Patient Name:	Chart#:	Date of Birth:	Today's Date:
Pharmacy Name:		Pharmacy Number:	
Pharmacy Address: (Street, City, State & Zip)		Patients Social Security:	

ALLERGIES	
Allergic To:	**Reaction:**

CURRENT MEDICATION REGIMEN			
Medication	**Dosage**	**Condition Use For**	**Prescribing Physician**

I certify that all the above information is corrected and up to date.

Signature: _____ Date: _____

Patrick F. O'Leary, M.D., F.A.C.S., P.C.
Spinal Surgery
1015 Madison Avenue
New York, NY 10075

Name:
Social Security #:

I hereby assign my right to receive payment from my insurance carrier to Patrick F. O'Leary, MD, FACS, PC and authorize my insurance carrier to make payment directly to Patrick F. O'Leary, MD, FACS, PC.

I certify that the information I have reported with regard to my insurance coverage is correct and that I will notify Patrick F. O'Leary, MD, FACS, PC of any change to such information or insurance coverage prior to the rendition of services on my behalf by Patrick F. O'Leary, MD, FACS, PC.

I hereby authorize Patrick F. O'Leary, MD, FACS, PC to release information acquired in the course of my examination or treatment to my insurance carrier, attorney, case manager, and in the case of workman's compensation related services, my employer, for purposes of verifying my benefits, securing payment and related purposes.

I direct my attorney and/or insurance carrier to pay Patrick F. O'Leary, MD, FACS, PC from any funds in settlement of my claim should there be any amounts due and owing at the time. I understand that if no settlement or award is made, or if, for some reason there is a balance due and owing subsequent to settlement, I will be personally and fully responsible for payment.

I am aware that Dr. O'Leary does not testify in court. Surgery is often scheduled months in advance. Attending court session is profoundly disruptive to patients who wish to be taken care of by Dr. O'Leary. For this reason, there are no exceptions.

_____ _____

Patients Signature Date

Patrick F. O'Leary, M.D., F.A.C.S., P.C.
Spinal Surgery
1015 Madison Avenue
New York, NY 10075

Name:
Soc.Sec #

HIPAA Privacy Notice:

This notice describes how medical information about you may be used and disclosed and how you can get access to his information. Please review it carefully.

Introduction: Patrick F. O'Leary, MD, FACS, PC understands that your medical information is private and confidential. Further we are required by law to maintain the privacy of "protected health information". "Protected Health Information" includes any individually identifiable information that we obtain from you or others that relate to your past, present or future physical or mental health, the health care you have received or payment for your health care.
As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer or you can access it on our website at www.pfol.com.

Other Uses and Disclosures of Protected Health Information: In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

Permitted Uses and Disclosures:

We can use or disclose your protected health information for the purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures we have provided a description below. However, not every particular use or disclosure in every category will be listed:

Treatment - means the provision, coordination or management of your health care including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Health Care Operations - means the support functions of our practice related to treatment and payment such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Payment - means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities.

I, _____knowledge that I have been provided with a copy of Patrick F. O'Leary, MD, FACS, PC's privacy notice.

_____ _____
Patient's Signature Date

Patrick F. O'Leary, M.D., F.A.C.S., P.C.
Spinal Surgery
1015 Madison Avenue
New York, NY 10075

AUTHORIZATION FORM FOR RELEASE OF MEDICAL RECORDS:

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. Any health information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by the Federal privacy regulations.

Name: S.S.#:

Persons/Organizations authorized to use/disclose or receive my information:

Name	Relationship	Phone	Address

Specific description of the information to be used to disclosed including date(s):

_____

Description of each purpose of the use or disclosure of my health information:

At the request of the patient.

I understand that this authorization will expire on: _____ Initials _____

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. Initials _____

I understand that I will get a copy of this form after I sign it. Initials _____

I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, the revocation will not have any effect on the actions the Practice has already taken in reliance on this authorization. Initials _____

_____ _____
Signature of patient Date

If this authorization is signed by a patient's representative, please complete the following:

_____ _____
Printed name of patient's representative Relationship to the patient