Jeffrey S. Oppenheim, M.D.*
Jeffrey W. Degen, M.D.*

2 Crosfield Avenue
Suite 102
West Nyack, NY 10994
845.368.0286
fax: 845.368.1653

75 Crystal Run Rd
Suite 205
Middletown NY 10941
845.673-1040
fax: 845.673-5879

21 Laurel Ave
Suite 290
Cornwall NY 12518
845.458.4874
fax: 845.458.4877

OFFICE REGISTRATION / MEDICAL SUMMARY

Patient Name ____ Today's Date _______________________

Patient Address ____

City ____ State ______________________ Zip _________________

Social Security # _________________________ Date of Birth ____________________ Age _______ Male____ Female____

Home Tel. # _________________________ Work Tel. # _______________________ Cell # _________________________

Email Address ____Pharmacy:_____________________________________

Primary Care Doctor ____ Tel # _____________________________

Whom may we thank for referring you? ____

Patient Employer & Address ____

Job Title & Description ____

Full-Time____ Part-Time____ Retired____ Homemaker____ Out of work since_________________________________

EMERGENCY CONTACT Name____

Relationship to Patient ____ Phone # __________________________________

MEDICAL INSURANCE (*Please circle one*) Medicare HMO Private No-Fault Worker's Comp Other

Primary Insurance Company ____

Subscriber Name _______________________________________ ID # _________________________________

Subscriber SS # ________________________________ Subscriber Date of Birth ____________________________

Secondary Insurance Company ____

Subscriber Name _______________________________________ ID # _________________________________

Subscriber SS # ________________________________ Subscriber Date of Birth ____________________________

WORKER'S COMP / NO FAULT

Indicate if current problem is due to *work*_____ or *car*_____ *accident*. If so, please complete following:

Date of Accident ___________________ Describe ____

If ***car accident***: Were you wearing seatbelt?______ Did air bag inflate?______ Any glass breakage?______

Damage $__________________ Year/model car ____

Hospitalized?_____ Where? ________________________________ When? ___________________________

Authorization to Release Information & Assignment of Benefits

I, ____, authorize the release of any medical information necessary to my insurance carrier to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Hudson Valley Brain and Spine Surgery to apply for benefits on my behalf for covered services rendered by them or by their order. I request that payment from my insurance company be made directly to Hudson Valley Brain and Spine Surgery. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for the charges incurred for services and supplies received from Hudson Valley Brain and Spine Surgery.

____ ______________________________

Signature (Patient or Parent/Guardian) *Date*

WHAT IS YOUR "CHIEF COMPLAINT"; WHAT PROBLEM ARE YOU BEING SEEN FOR TODAY?____________

____

Have you used any of the following? (*Please circle & describe*) **Physical therapy** **Chiropractic** **Pain Injections**

When, how long, by whom? ____

ALLERGIES to MEDICATIONS ____

OTHER MEDICAL PROBLEMS OR INJURIES (Please list) _________________________________

____

SURGERIES / HOSPITALIZATIONS (Include year) _____________________________________

____

HAVE YOU EVER SEEN A CARDIOLOGIST? Y / N If YES, doctor's name: ___________________

***PLEASE EXPLAIN____

CURRENT MEDICATIONS (use separate sheet for >5) Name_______________dose________freq________

Name_______________dose__________freq._______. Name_________________dose________freq________

Name_______________dose__________freq._______. Name_________________dose________freq________

FAMILY HISTORY:	**ALIVE / DECEASED**	**AGE**	**HEALTH STATUS / CAUSE of DEATH**
Mother	A / D	______	______________________________
Father	A / D	______	______________________________
Sister/Brother	A / D	______	______________________________
Sister/Brother	A / D	______	______________________________

Height _____________ Weight ______________ Right-handed _____ Left-handed _____

Last Pap smear: Date __________________ Result ____________________________________

Marital status: (*Please circle*) Single Married Divorced Widowed

Children: (*Please circle*) No Yes If yes, how many? _______

Do you smoke? (*Please check one*)

_____ No, I have never smoked.

_____ No, I quit ______ years ago. Prior to that, I smoked ______ pack(s) per _________ for ________ years.

_____ Yes, I smoke ______ pack(s) of cigarettes per ____________and have been smoking for ________ years.

Do you drink alcohol? (Please circle) No Yes If yes, how many drinks per week? ____________

Please circle any of the following that apply, and describe.

Constitutional: Fever Wt loss Excessive fatigue sweats

Eyes: Infections Injuries Glaucoma Cataracts

ENT: Hearing aid Hearing loss Ear pain Infection

Ringing in ears Dizziness Nosebleeds Sinus problems Sore throat

Heart: Chest pain Hypertension Heart murmur Irregular pulse

Swollen hands/feet High cholesterol Heart attack / Heart disease

Lungs: Asthma Cough Emphysema Shortness of breath

Bronchitis Congestion Pneumonia Lung cancer Sleep apnea

Digestive: Indigestion Nausea Vomiting Liver disease Hepatitis

Jaundice Abdominal pain GERD Colon cancer

Urinary: Urinary tract infections Incontinence Blood in urine Cancer

Muscular: Right/Left arm/leg weakness/numbness Neck pain

Back pain Arthritis Joint swelling Broken bones

Neuro: Fainting Seizures Memory loss Disorientation Headache

Difficulty with speech Inability to concentrate Double vision

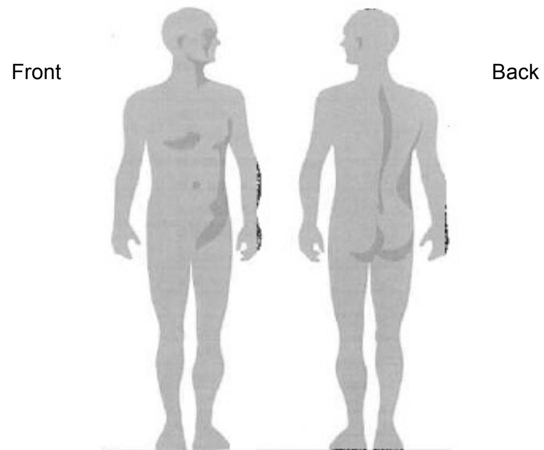
Face weakness Anxiety Depression Psychiatric disorder

Endocrine: Diabetes Thyroid disease Excessive thirst or urination

Blood: Anemia Hemophilia Bleeding tendencies

Transfusions (if yes, when: ___________)

Blood Thinners: Heparin Coumadin Aspirin NSAIDs



If you have pain, please shade the area that is painful

DIAGNOSTIC STUDIES

CAT Scan Y / N Body part scanned____________________ Where______________________________When_________________

MRI Scan Y / N Body part scanned____________________ Where______________________________When_________________

EMG Y / N Body part studied____________________ Where______________________________When_________________

I have reviewed the above information with the patient.

Doctor Signature ____ *Date* ______________*Time*__________

Hudson Valley Brain and Spine Surgery

Authorization for Release of Records or Information Form (Authorization Form)

INSTRUCTIONS

This form is to be completed by the patient to allow other individuals to receive information about his/her medical or claims records. The Authorization Form is valid for one year from the date you sign the form.

SECTION A

Please insert the patient's name and social security number in the spaces provided.

SECTION B

In "**Personal Health Information to be Disclosed**" section, write the specific personal health information to be released. **For example**: "the medical records related to my treatment by Hudson Valley Brain and Spine Surgery."

In the "**Persons/Entities Authorized to Receive and Use**" section, specify the individual, organization, or institution to whom you are releasing information. **For example**: attorney, family member, insurance company, disability carrier, etc.

In the "**Purpose of Disclosure**" section, explain why you are releasing your personal health information. **For example**: "to answer questions about my treatment."

The "**Right to Revoke**" section allows you to stop the authorization for release of records anytime during the year after the form is submitted. To revoke your Authorization Form, please contact our office.

SIGNATURE SECTION

Please remember to sign and date the form.

HUDSON VALLEY BRAIN AND SPINE SURGERY
Authorization for Use and Disclosure of Private Health Information

SECTION A: I authorize the disclosure of my personal health information as described in Section B below. I understand this authorization is voluntary and made to confirm my directions. I hereby give my permission to Hudson Valley Neurosurgical Associates, LLC (d/b/a Hudson Valley Brain and Spine Surgery), to disclose my personal health information in the manner described herein.

Patient Name____ SS#_________________________

SECTION B: Personal Health Information to be Disclosed: Describe the personal health information you are authorizing to be used and/or disclosed:

____

Persons/Entities Authorized to Receive and Use: Name or specifically describe the persons and/or entities to whom you are authorizing the entity named above to disclose or let use the personal health information described above:

____

____

Purpose of the Disclosure: The disclosure is being made for the following reason:

____

____

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this authorization will expire one (1) year after the date on which the authorization is signed. To revoke the authorization, I will contact you.

SIGNATURE SECTION:

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the entity named above. I understand that, by signing this form, I am confirming my authorization that the entity named above may use and/or disclose to the persons and/or organizations named in this form the nonpublic personal health information described in this form.

SIGNATURE: _______________________________________ **DATE:** ___________________

See instructions on reverse side.

For Cornwall patients
Since we share our office with other medical doctors and staff that are not part of our practice, we will do our utmost to protect your privacy.

HUDSON VALLEY BRAIN AND SPINE SURGERY

Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED WITHIN THIS ORGANIZATION, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.

Hudson Valley Neurosurgical Associates, LLC (d/b/a Hudson Valley Brain and Spine Surgery, HVBSS), is required by law to maintain the privacy of your personal medical information and to provide you with this notice of its privacy policies.

USES AND DISCLOSURES:

Treatment: HVBSS may use your information to provide or coordinate your care. We may disclose all or any portion of your medical information to any of our physicians, other consulting or referring physicians, nurses or nurse practitioners, physician assistants, and other employees who have legitimate need for such information to provide or coordinate your care.

Payment: We may release your information to determine coverage by an insurer for our services, and for billing and claims processing. The information may be released to an insurance company, third-party payer, or other organization involved in the payment of your bill. This information may include copies or excerpts of your medical information that is necessary to receive payment.

Healthcare Operations: We may use and disclose your information during routine operation of the practice. For example, we would contact you to remind you of an appointment or to disclose information to a transcriptionist or consultants working for the practice. These entities are called "Business Associates." We require our Business Associates to treat your information in the same manner that we do.

Research: Under certain circumstances, we may use and disclose your information within approved clinical research studies. Most clinical research studies require specific patient consent; however, there may be some cases where a review of your information without patient contact may be conducted by the researchers.

Regulatory Agencies: We may disclose your information to state, local, or federal agencies authorized by law to conduct inspections, audits, or investigations of the practice.

Law Enforcement/Litigation: We may disclose your information for valid law enforcement purposes as required by law or in response to a court order or subpoena.

Public Health: We may disclose your information to public health authorities as authorized by law and related to the prevention or control of certain diseases.

Worker Compensation: We release your information to Worker Compensation agencies in the event your illness or injury may be related to your work.

Military/Veterans: If you are a member of the armed forces or a veteran, we may release your information as required by military command authorities.

As Otherwise Required: We may disclose your information in any situation in which such disclosure is required by law (for example, child or domestic abuse).

Prohibited Uses: We will not disclose your information to persons outside the practice for purposes other than treatment, payment, or healthcare operations without your authorization in writing. If you provide such authorization to us, you may revoke it in writing at any time in the future and we will honor that request.

Your Rights Related to Your Health Information: Although all records concerning your treatment at HVBSS are the property of HVBSS, you have certain rights concerning this information as follows:

- **Right to Confidentiality:** You have the right to receive confidential communication of your health information by alternative means or at alternative locations, if you so request in writing.
- **Right to Respect and Copy:** You generally have the right to inspect and receive a copy of your health information from HVBSS, unless that is restricted by law or by your physician.
- **Right to Amend:** You have the right to request an amendment or correction to your health information. If we agree that information is appropriate, we will include that information in your medical record.
- **Right to Accounting:** You have the right to obtain a record of disclosures that we make of your health information for other than treatment, payment, or routine operation of the practice.
- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. We will abide by these requests to the extent that we are able.
- **Right to Revoke Authorization:** You have the right to revoke your prior authorization to release your health information except to the extent that action was taken in reliance on your original authorization.
- **Right to Complain:** You have the right to formally complain about our handling of your health information. You may contact our practice representative or the Department of Health and Human Services. If you complain, we will not retaliate against you in any way.
- **Changes to this Notice:** HVBSS will abide by the terms of this notice currently in effect. However, HVBSS reserves the right to change the terms of the notice at any time. Any new notice provisions will be effective for all health information from the time that the changes are effective within HVBSS.

Effective Date of this Notice: April 14, 2003

HUDSON VALLEY BRAIN AND SPINE SURGERY

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

(After review of this document, please sign and return to the receptionist.)

I, ____, hereby acknowledge that I have received and reviewed the "Notice of Privacy Practices" which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations.

____ ____________________________

Signature of Patient or Patient's Representative Date

____

Printed Name of Patient or Patient's Representative

____

If Representative, Specify Relationship