Regenerative Spine & Musculoskeletal Medicine
RSM

3400 Vickery Road
Syracuse, NY 13212

8 Hulbert Street
Auburn, NY 13021

(315) 701-4000 www.RSMMD.com

You have an appointment with _____on _____at _____AM/PM at our □ Vickery Road Office □ Auburn office.

Thank you for choosing Regenerative Spine & Musculoskeletal Medicine, to assist with your healthcare concerns. We would like to take this opportunity to welcome you to our practice. We specialize in all aspects of musculoskeletal care, including the diagnosis and treatment of spine, shoulder, elbow, hip, knee, arthritis, muscle, and no-fault or work related injuries. Our office offers an on-site procedure suite, EMG testing, platelet rich plasma (PRP) injections, prolotherapy, acupuncture, nutritional guidance and supplements. Enclosed you will find paperwork that must be filled out **BEFORE** you arrive for your appointment, along with some of our practice policies.

Our goal is to provide excellent personalized care to help our patients achieve a satisfying quality of life by reducing pain and optimizing function. Dr. Renée S. Melfi has been providing comprehensive treatment of spine and musculoskeletal conditions for over 15 years in Central New York. Physical Medicine and Rehabilitation (PM&R) physicians, or physiatrists, are nerve, muscle, bone, and brain experts who treat injury or illness non-surgically to decrease pain and restore function. The Physiatric approach to patient care looks at the whole person and not just one symptom or condition. The subspecialty of Interventional Physiatry uses image-guided needle placement for the delivery of medication in order to diagnose or treat a number of conditions affecting the spine or other areas of the musculoskeletal system.

As interventional physiatrists, the prescription of opioid pain medications is **NOT** a focus of this practice. Those seeking solely the continuance of an opioid pain medication previously written by a different provider may wish to seek care in a different practice. If you ask that we become involved in the prescription of any opioid medications, please be aware our goal will be to safely wean the medication to episodic, acute use, if any at all.

At Regenerative Spine & Musculoskeletal Medicine, we pride ourselves on personalized care in a timely fashion. We will do our best to attempt to stay on time, although sometimes medical emergencies occur and can interrupt our schedule. You can help us to stay on time by arriving on time for your appointments. Please arrive 30 minutes early for your appointment if you have **NOT** completed your paperwork. If paperwork is completed, please arrive 15 minutes early for your appointment. If you check in 15 minutes after your appointment time, we may cancel and reschedule your appointment. If you are unable to keep your appointment, 24 hours notice is required.

Our staff is available to speak with you Monday through Friday from 8:00-4:00 to answer your questions. Our secretaries will triage your message to the nursing staff and your call will be returned as it was received, or depending on medical importance. While clinic is not interrupted for phone calls, we will make every attempt to return your call in a timely manner. We can best answer your questions and attend to your medical needs while the office is open and we have access to your chart.

Care that must be rendered by telephone and outside of a certain time frame after your appointment may be billed to your insurance company. Please be aware you may be required to pay a co-pay. Prescription refills, or requests for completion of disability paperwork will be completed within seven days. In some instances you may need to schedule a follow-up appointment to review your medical status.

This office contains both procedure suites and examination rooms where sensitive medical procedures are performed. Due to this, no person(s) under the age of 14 years will be allowed in the examination rooms or procedure suite unless they are the patient.

CHECKLIST OF ITEMS TO BRING FOR YOUR APPOINTMENT

- ☐ Completed patient registration form (enclosed).
- ☐ Completed medical history form (enclosed) AND related medical records.
- ☐ Signed Financial Agreement form (enclosed).
- ☐ Insurance Identification cards and driver's license.
- ☐ Any X-Rays, CT Scans, MRI studies on CD, with reports.
- ☐ Patient referral from your primary care physician if required by your insurance company.
- ☐ **Workers Compensation AND No Fault Auto Injuries**: You **must** have your date of injury, insurance copay claim number, policy number, name of the insurance carrier with their address and telephone number. **IF YOU DO NOT PRESENT THIS INFORMATION AT THE TIME OF YOUR APPOINTMENT, YOU WILL BE SEEN UNDER YOUR PROVATE INSURANCE, OR THE APPOINTMENT MAY BE CANCELLED.**
- ☐ Please bring shorts and a t-shirt if you wish to avoid changing into a gown.
- ☐ If the patient is under 18 years old, he/she must be accompanied by a parent/guardian or have written consent of a parent or guardian.
- ☐ Please refrain from wearing perfumes, colognes, scented lotions to your appointments.

We know how precious your time is, so please arrive promptly for your appointment, with all paperwork completed in advance. This time has been reserved for you. Failure to arrive on time or bring all pertinent information may result in delay or the need to reschedule your appointment.

Please visit our website at **www.rsmmd.com** or call 315-701-4000.

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NEW PATIENT HISTORY

Name: _____ **Age:** _____ ☐ **Right-handed** ☐ **Left-handed**

DOB: _____ **E-Mail:** _____

Primary Care Physician: _____

What main problem brings you here today? _____

This pain is related to: ☐ work ☐ auto accident ☐ sports ☐ other

If **work related**, have you had any previous work related injuries? ☐ Yes ☐ No
If **motor vehicle related,** have you had any previous motor vehicle related injury? ☐ Yes ☐ No

Date when your symptoms started: _____

Describe HOW your pain started: _____

_____

Did you go to the emergency room or urgent care? ☐ Yes ☐ No

PRIMARY SITE OF PAIN (NAME ONE REGION): _____

Describe your PRIMARY PAIN (check all that apply): ☐ achy ☐ burning ☐ deep ☐ dull ☐ electrical ☐ numb ☐ sharp ☐ shooting ☐ stabbing ☐ tingling

Your PRIMARY PAIN is... ☐ Constant ☐ Comes and Goes

OTHER SITES OF PAIN: _____

Your pain is:

☐ Worse	☐ No Change	when coughing
☐ Worse	☐ No Change	when lying down
☐ Worse	☐ No Change	when sitting
☐ Worse	☐ No Change	when sneezing
☐ Worse	☐ No Change	when standing
☐ Worse	☐ No Change	when rising up from a chair

Your pain is BETTER with:
- ☐ Position change
- ☐ Rest
- ☐ Standing
- ☐ Sitting

Are you CURRENTLY enrolled in:

☐ Physical Therapy	☐Better	☐Same	☐Worse
☐ Chiropractic	☐Better	☐Same	☐Worse

Do you need help with any of these activities? (check all that apply): ☐ bathing ☐ dressing ☐ driving ☐ housework ☐ (mobility) walking ☐ climbing stairs ☐ toileting

PREVIOUS Treatments:

☐ Chiropractic Care	☐Better	☐Same	☐Worse	When _____	Where performed? _____
☐ Massage Therapy	☐Better	☐Same	☐Worse	When _____	Where performed? _____
☐ Physical Therapy	☐Better	☐Same	☐Worse	When _____	Where performed? _____
☐ Epidural Injections				When _____	Where performed? _____
☐ Trigger Point Injections				When _____	Where performed? _____

List in order physicians you have seen for this problem:

_____

_____

What medicines have you tried:

_____

_____

If injured in a car accident, you were the... ☐ driver ☐ passenger
☐ rear-end collision ☐ broad sided ☐ side swiped
Wearing seatbelt? ☐ Yes ☐ No
Air bag deployed? ☐ Yes ☐ No
Lost consciousness? ☐ Yes ☐ No

Name: _____ **Date:** _____

Allergies to medications: _____

_____

Are you allergic to:

Iodine?	☐Yes ☐No
Seafood?	☐Yes ☐No
Dye/Contrast?	☐Yes ☐No
Latex?	☐Yes ☐No
Novocain?	☐Yes ☐No

List ALL Medical Illnesses/Diseases: _____

_____

_____

_____

List Past Surgeries and dates: _____

_____

_____

_____

Current Medications and dosage: _____

_____

_____

_____

_____

Illnesses that run in your family: _____

_____

_____

_____

Social History:
Alcohol: Drinks per week _____
Tobacco: ☐ Never ☐ Quit ☐ Yes, _____ pack/day for _____years
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other
#Children_____
Occupation: _____
Currently working? ☐Yes ☐No ☐Retired

Lately, have you experienced (in the last month)...
Const: ☐ poor appetite ☐ fatigue ☐ fever ☐ weight gain ☐ weight loss
Eyes: ☐ vision changes
ENMT: ☐ hearing changes ☐ nose bleeds ☐ gums bleeding ☐ sore throat
CVS: ☐ chest pain ☐ murmurs ☐ palpitations ☐ swollen feet
Resp: ☐ cough ☐ shortness of breath ☐ wheeze
GI: ☐ abdominal pain ☐ bowel incontinence ☐constipation ☐ diarrhea ☐ heartburn ☐ vomiting
GU: ☐ frequency of urination ☐ incontinence of urine ☐ kidney stones ☐ sexual difficulties
Musc: ☐ muscle cramps ☐ gait disturbance ☐ joint pain ☐ muscle pain ☐ joint swelling
Skin: ☐ dry skin ☐ rashes ☐ excessive sweating ☐ hair changes ☐ nail changes
CNS: ☐ dizziness ☐ fainting ☐ headaches ☐ memory loss ☐ paralysis ☐ tremor ☐ weakness
PSY: ☐ anxiety ☐ difficulty concentrating ☐ depression ☐ insomnia
Endo: ☐ cold intolerance ☐ heat intolerance ☐ excessive thirst
Heme: ☐ bruising ☐ swollen glands

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Patient Registration Form

Please Print

*Date*_____

Name:_____ Sex ___F ___M SS#_____
Address:_____City_____Zip_____
Mailing Address (If different than above)_____
Phone_____ Cell Phone_____ Age_____ DOB _____
Marital Status: Single_____ Married____ Divorced/Separated_____ Widow/Widower_____
Patients Employer_____ Occupation_____
Employers Address_____ Work Phone_____
Emergency Contact_____ Phone _____
Spouse/Significant Others Name_____ Mother's Maiden Name_____
Spouse/Significant Others DOB:_____ SS#_____
Spouse's/Significant Others Employer _____ Occupation_____
Employers Address _____Work Phone_____
Pharmacy Name & Address_____ Pharmacy Phone #_____
Language Preference_____ Race_____ Email _____
Ethnicity Non-Hispanic/Spanish Origin ____ Spanish/Hispanic Origin_____ Patient Declined/Unknown_____

INSURANCE INFORMATION

Primary Insurance Company:_____Subscriber Name:_____
ID#:_____ SS#:_____DOB:_____
Secondary Insurance Company.:_____ Subscriber Name:_____
ID#:_____

HIPAA DOCUMENTATION

(Please answer all questions below and then sign and date)

1 I acknowledge that I have been given the opportunity to read and/or receive a copy of Family Care Medical Group's Privacy Notice. YES NO

2.

Leave appointment message on:	**YES**	**NO**
Home Phone (including autocall)?		
Mobile Phone (including autocall)?		
Mobile Text (including autocall)?		
Work Phone?		
With another person? List name(s) below		
Send via Mail?		
Send via Email?		

Leave Medical information on:	**YES**	**NO**
Home Phone (including autocall)?		
Mobile Phone (including autocall)?		
Mobile Text (including autocall)?		
Work Phone?		
With another person? List name(s) below		
Send via Mail?		
Send via Email?		

3. Person(s) authorized to discuss the above information & relationship

_____ _____

_____ _____

Signature_____ Date_____

*** I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signature_____ Date_____

*** I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

Signature_____ Date_____

RSM Regenerative Spine & Musculoskeletal Medicine
Workers Compensation/No Fault

Name: Last-	**First-**		**Middle Initial-**
Date of Birth: **Age:**	**SS#:**		**Male/Female**
Address:			**Apt. #**
City:	**State:**	**Zip Code:**	**Phone #:**
Occupation:	**Employer:**		**Phone #:**
Employer Address:			**Phone#:**
Emergency Contact:			**Phone#:**
Spouse:	**SS#:**		**Phone#:**
Who may we thank for this referral:	**Address:**		**Phone#:**
Family Physician:	**Address:**		**Phone#:**
Attorney:	**Address:**		**Phone#:**

WORKERS COMPENSATION INFORMATION

Injury #1 Insurance Carrier:		**Date of Injury:**
Address:		**Phone #:**
WCB#:	**Carrier Case#:**	**Area Injured:**
Employer at the Time of Injury:		
Address:		**Phone #:**
Contact Person:		**Phone#:**
Address:		**Phone #:**
Job Title:		
Are you working? (circle one) YES NO		

NO FAULT (AUTOMOBILE) INFORMATION

Insurance Carrier:		
Address:		**Phone#:**
Date of Accident:	**Area Injured:**	**Policy#:**

I authorize release of medical information necessary to process claims and authorize payment of medical benefits to Dr. Renée S. Melfi . I authorize release of medical information to my referring physician.

Signed: **Date:**

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: _____

I, _____ (Print patient's name), **("Assignor") hereby assign to** _____ (Print hospital or health care provider name), **("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.**

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), **not withstanding any other agreement to the contrary.**

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ **(Print name of Patient)**

_____ **(Signature of Patient)**

_____

_____ (Date of signature)

_____ (Address of Patient)

_____ **(Print name of Provider)**

_____ **(Signature of Provider)**

_____

_____ (Date of signature)

_____ (Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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OFFICE POLICIES AND FINANCIAL AGREEMENT

BILLING POLICY - Our office is a proud member of Family Care Medical Group. Our practice participates with many insurance carriers. You are responsible for providing sufficient billing information and determining whether our services are covered by your insurance contract. If we are participating providers with your insurance company, we will bill your insurance directly. In the event your insurance determines a service to be "not covered," you will be responsible for the payment in full. If we do not participate with your insurance, you are responsible for payment in full at the time of service.

CO-PAYMENTS/CO-INSURANCE/DEDUCTIBLES - Your insurance carrier mandates that we collect the amount of the deductible, co-insurance, or co-payment specified in your contract. **Payment is expected at the time of check-in for your appointment.** We reserve the right to reschedule your appointment if you are unprepared to pay.

PAYMENTS - We accept payment in the form of cash, checks, money order or Visa/MasterCard/Discover. A $25 fee will be assessed for a check returned by your bank. Payments are due at the time services are provided or upon receipt of a statement from our billing office. If after 60 days a payment has not been made the account may be referred to a collection agency. If you have an unpaid balance, we will be unable to make another appointment until this balance is addressed. If you make no attempt to satisfy any outstanding balances, the practice reserves the right to discharge the patient from the practice.

RECORDING DEVICES – The use of recording devices, both visual and audio is **PROHIBITED** in this office and treatment rooms at all times.

NO-SHOW POLICY/SAME-DAY CANCELLATION - Delivering quality patient care is the primary focus of this practice. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand and limited availability of appointments this office's no show/late cancel fee is **$50.00 for office visits; $150.00 for injection procedures.** Insurance will NOT cover charges for no-show fees. You are personally responsible for payment, which must be made prior to your next visit. You must give **24 hour advance notice** to cancel/reschedule appointments. If there are two late cancellations/no shows we reserve the right to discharge you from this practice for non-compliance.

LATE SHOW POLICY - Our providers know your time is important and we hope you understand the value of our time. We want to be able to provide every patient with all the attention they require. Therefore, if you are **10 minutes** or more late for your appointment, it may be necessary to reschedule for a later time or day. It is at the discretion of the provider to see the patient or to ask the patient to reschedule. If it is determined that the provider will see the patient, the patient arriving late may have to wait until an appropriate opening is available.

WORKERS' COMPENSATION AND MOTOR VEHICLE ACCIDENTS - If Workers' Compensation or No Fault is your primary insurance, you are responsible for providing us with accurate information regarding the date of the injury, WCB and Carrier Case numbers, and the insurance company's name and address. If you case is denied, all outstanding balances and future services will be your responsibility unless you have private insurance. In order for our office to bill your private health insurance, all information must be provided at your initial visit to insure timely filing of your claim.

EMERGENCY ON-CALL PROVIDER POLICY - An afterhours on-call provider is available for **emergencies only for questions related to recent injection procedures.** please do NOT call the on-call emergency phone number for questions related to refills, medication questions, scheduling or authorization questions. Calls to the on-call emergency phone number for such non-emergency issues will NOT be returned until the next business day. Failure to follow this policy may result in discharge from this practice.

FORM COMPLETION - There is an administrative fee of $25.00 per form, and fees must be paid in full prior to completion. These fees are not covered by insurance. The form fee does not apply to forms received on letterhead from the Workers' Compensation carrier, No-Fault carrier, or Employers regarding your Workers' Compensation Claim, **except all FMLA forms incur a charge of $25 regardless of requestor.** All forms require 7 business days to process.

RECORDS REQUEST - There is an administrative fee of $0.75 per page for medical records requests. This fee is not covered by insurance, and must be paid prior to completion. All requests for medical records are required to be in writing.

By signing below, I certify that I have read, understand and agree to all above stated terms.

_____ _____

Patient/Guardian Signature Today's Date