

## COMPREHENSIVE SPINE CARE, PA.

ARI BEN-YISHAY, M.D.  
Adult and Pediatric Spinal Surgery

JONATHAN P. LESTER, M.D.  
Physical Medicine and Rehabilitation

RAFAEL LEVIN, M.D.  
Adult and Pediatric Spinal Surgery

Dear Patient,

It is the mission of our practice to have a strong and supportive relationship with our patients. The following information should be useful to you.

If you have any questions, feel free to call our office at (201) 634-1811. Our staff will be happy to assist you.

### OFFICE HOURS

- Our Emerson office hours are: Monday – Thursday 9:00 – 5:00
- Friday 9:00 – 3:00. (201) 634-1811
- Our Fair Lawn office hours are: Monday 1:00 – 5:00, Tuesday 9:00 – 4:00
- Wednesday: 9:00 - 12:00, Friday 9:00 – 11:30.

### APPOINTMENTS

- If you need to cancel your appointment, please notify our office as soon as possible. The office numbers are listed above.

### PRESCRIPTIONS

- If you have been prescribed a medication by one of our doctors and you need a refill, please call 2-3 days before the prescription runs out.
- When calling for a refill, please have your pharmacy name and number ready to give to our staff.
- Please call no later than 1 hour before the office closes. Time is needed in order to check with the physician for authorization.
- If you need additional physical therapy visits please notify our office 5-7 days before the prescription runs out. We may need to obtain further authorization from your insurance company. This will ensure that there is no gap in your treatment.

### X-RAYS, MRI'S & CT SCANS

- Please be sure to bring the actual films with you to EACH appointment. The films should be kept dry and out of the sun.

466 OLD HOOK ROAD, SUITE 16, EMERSON, NJ 07630, TEL #20-634-1811, FAX #201-634-9170  
28-04 BROADWAY, FAIRLAWN, NJ 07410

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_

Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Sex: Male Female Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Retired or Homemaker

Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Is today's visit related to an Auto Accident or Work Injury (circle one)

**INSURANCE INFORMATION**

Name if Insured \_\_\_\_\_ SS# of insured \_\_\_\_\_

Name of Primary Insurance Co \_\_\_\_\_ Phone # \_\_\_\_\_

Address of Carrier \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

Employer of insured \_\_\_\_\_

Address of Employer \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Employer's Phone # \_\_\_\_\_

Subscriber Sex: Male Female Subscriber Date of Birth \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**SECONDARY INSURANCE**

Name of insured \_\_\_\_\_ SS# of insured \_\_\_\_\_

Subscriber Date Of Birth \_\_\_\_\_ Subscribers sex: Male/ Female Relationship to patient \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Address \_\_\_\_\_

Insurance Phone # \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_

Address \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Relationship \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone# \_\_\_\_\_

sated \_\_\_\_\_

DATE \_\_\_\_\_ NAME \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SMOKER: YES NO AMOUNT PER DAY \_\_\_\_\_ ALCOHOL: YES NO HOW OFTEN \_\_\_\_\_

MEDICAL HISTORY:	YES	NO	FAMILY	YES	NO
DIABETES	___	___		___	___
CANCER	___	___		___	___
HIGH BLOOD PRESSURE	___	___		___	___
ASTHMA	___	___		___	___
KIDNEY DISEASE	___	___		___	___
ULCERS	___	___		___	___
ARTHRITIS	___	___		___	___
DEPRESSION	___	___		___	___

ALLERGIES:	YES	NO	NAME OF DRUG	REACTION
ANTIBIOTICS	___	___	_____	_____
SHELLFISH/IODINE	___	___	_____	_____
MEDICATIONS	___	___	_____	_____
ANESTHESIA	___	___	_____	_____

MEDICATIONS PRESENTLY TAKING \_\_\_\_\_  
\_\_\_\_\_

PAST SURGICAL PROCEDURES AND DATE \_\_\_\_\_  
\_\_\_\_\_

COULD YOU BE PREGNANT TODAY? \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

FAMILY HISTORY	ALIVE/WELL NUMBER OF EACH	DECEASED/NATURE OF DEATH
PARENTS	_____	_____
SIBLINGS	_____	_____
CHILDREN	_____	_____

Name \_\_\_\_\_ Date \_\_\_\_\_

**Please check all positive conditions**

- **General:** \_\_\_ Fever \_\_\_ Chills \_\_\_ Unexplained weight loss \_\_\_ Cancer
- 
- **Eyes:** \_\_\_ Glaucoma \_\_\_ Blurred Vision \_\_\_ Other \_\_\_\_\_
- 
- **Cardiac** \_\_\_ Shortness of Breath \_\_\_ Chest Pain \_\_\_ Irregular heart beat
- \_\_\_ Palpitations \_\_\_ High Blood Pressure \_\_\_ Other \_\_\_\_\_
- 
- **Vascular:** \_\_\_ Swelling of feet and ankles \_\_\_ Other \_\_\_\_\_
- 
- **Neurologic:** \_\_\_ Frequent Headaches \_\_\_ Seizures \_\_\_ Double Vision
- \_\_\_ Ringing in ears \_\_\_ Dizziness \_\_\_ Other \_\_\_\_\_
- 
- **Urinary:** \_\_\_ Frequent urination \_\_\_ Hesitancy \_\_\_ Blood in urine
- \_\_\_ Painful urination \_\_\_ Kidney Disease
- 
- **Gastrointestinal:** \_\_\_ Nausea \_\_\_ Vomiting \_\_\_ Blood in Stool \_\_\_ Heartburn
- \_\_\_ Ulcers \_\_\_ Other \_\_\_\_\_
- 
- **Respiratory:** \_\_\_ Shortness of Breath \_\_\_ Wheezing \_\_\_ Coughing
- \_\_\_ Asthma \_\_\_ Other \_\_\_\_\_
- 
- **Musculoskeletal:** \_\_\_ Arthritis \_\_\_ Joint Swelling \_\_\_ Other \_\_\_\_\_
- 
- **Endocrine:** \_\_\_ Thyroid Abnormalities \_\_\_ Cold or Heat Intolerance
- \_\_\_ Diabetes \_\_\_ Other \_\_\_\_\_
- 
- **Skin:** \_\_\_ Rashes \_\_\_ Other \_\_\_\_\_
- 
- **Blood:** \_\_\_ Anemia \_\_\_ Easy bruising or bleeding \_\_\_ Past blood transfusion
- \_\_\_ Other \_\_\_\_\_
- 

**All systems are NEGATIVE:** \_\_\_ YES \_\_\_ NO

**PATIENT SIGNATURE** \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

WHERE IS YOUR PAIN NOW?

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS

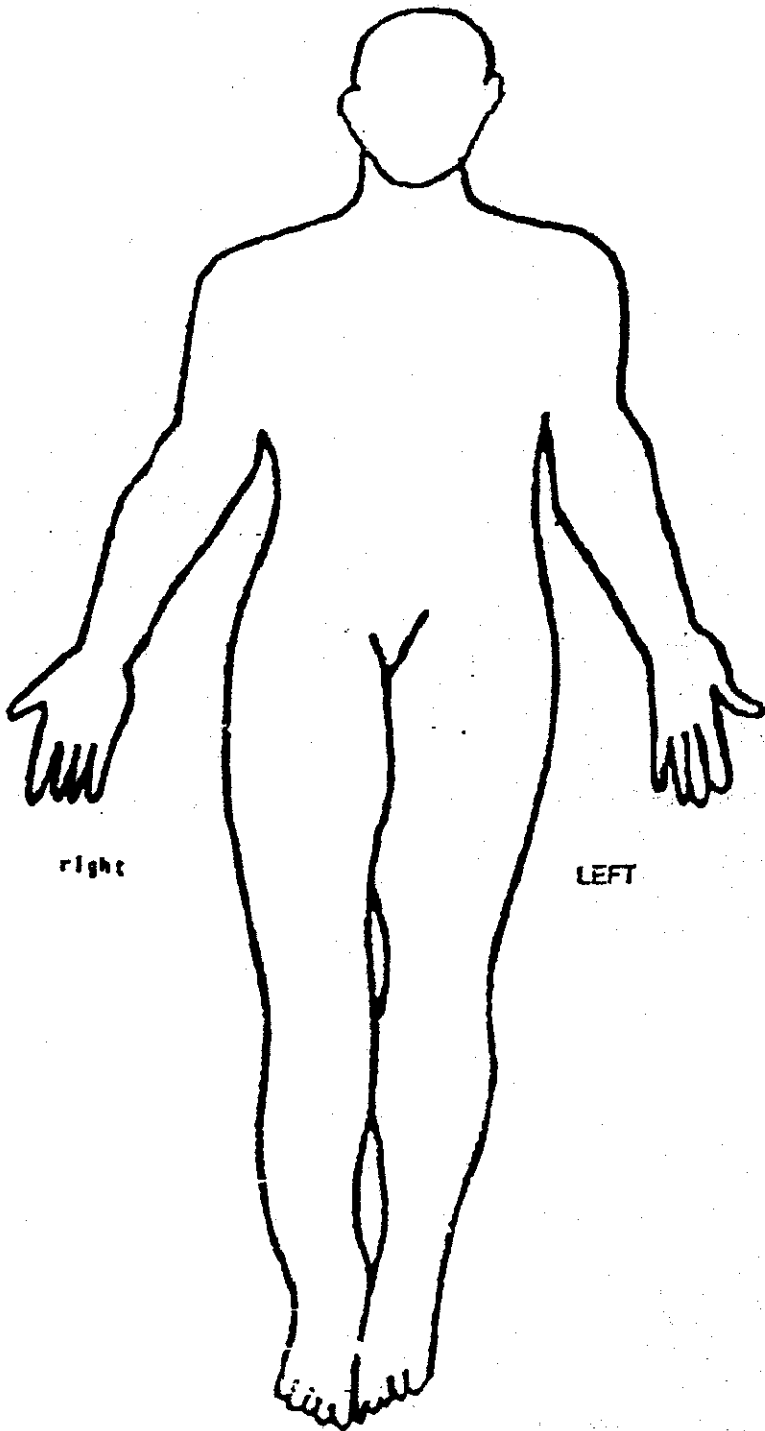
ACHE  
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PINS & NEEDLES  
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BURNING  
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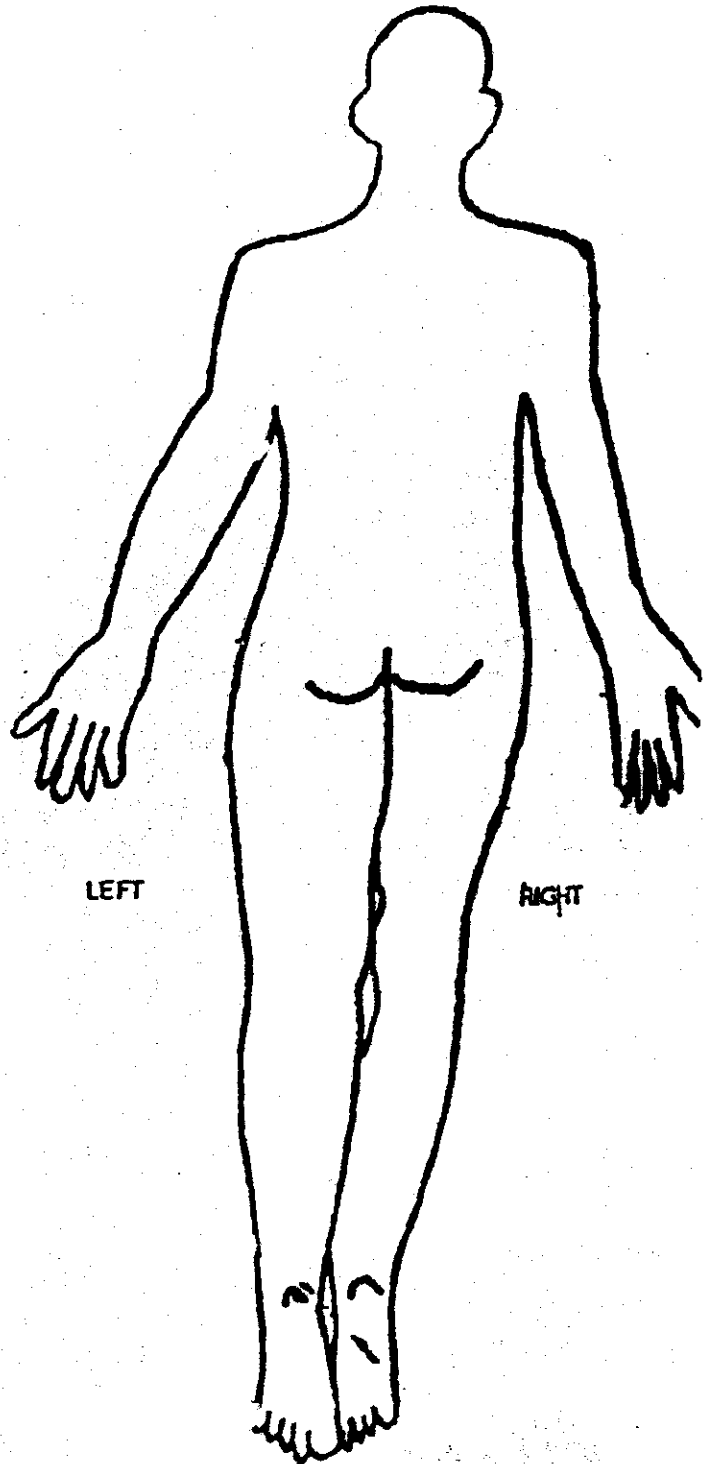
STABBING  
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right

LEFT

FRONT



LEFT

RIGHT

BACK

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## FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below.

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization.

     All information / no restrictions.

     Restrictions as listed \_\_\_\_\_  
\_\_\_\_\_

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information.

     Physician Ari Ben-Yishay, M.D.

     Physician staff (medical assistant, receptionist, biller, collectors)

3. I authorize the following persons (or class of persons) to receive my protected health information.

     Family (please list names) \_\_\_\_\_  
\_\_\_\_\_

     No fault carriers (automobile) and adjusters associated with no fault (automobile)

     Medical insurance company

     Workers compensation including adjusters and case managers associated with my case, and any insurance claim review companies associated with the workers compensation insurance.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

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MAILING ADDRESS: P.O. BOX 631, WESTWOOD, NJ 07675

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon 3 years after my last treatment by Comprehensive Spine Care, P.A. and/or Comprehensive Physical Therapy.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Comprehensive Spine Care, P.A., nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request for the following purpose.

Obtaining authorization for treatment  
Disability (with proper authorization)  
Scheduling treatment (hospital, out patient facility, physical therapy facility, pain management facility, diagnostic facility)

Social Security (with proper authorization)  
Collecting payment for medical services  
Attorney (when appropriate authorization from attorney is received)  
Billing for medical services  
Referral to other physicians by Comprehensive Spine Care, P.A.

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed.

10. Changes to the above document must be submitted in writing to Comprehensive Spine Care, P.A. changes will be effective immediately upon receipt of request.

By signing this form, you are granting consent to Comprehensive Spine Care, P.A. and/or Comprehensive Physical Therapy to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling 201-634-1811.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name of personal representative

\_\_\_\_\_  
Relationship to patient

If you have any please feel free to speak to any of the staff members.

Thank You,  
Comprehensive Spine Care, P.A.