Jessica R. Berman, MD
Rheumatology
535 East 70th Street
New York, NY 10021
Tel: 212.774.7501 • Fax: 212.606.1577

LATE PATIENT POLICY

To My Patients:

Living, traveling and working in New York City is usually not so easy. I am well aware of this. Often we run behind for reasons that are not always under our control.

I may run late in my practice because of emergencies and phone calls from patients each day, although this is rare.

However, in an effort to be fair to all my patients (including those who are on time), if you are late for an appointment, we will try to accommodate you at the earliest possible time. However, follow-up patients who were on time for their appointments will be seen first. Sometimes, you may find it preferable to reschedule an appointment rather than wait. However, please be sure to let the nurse know if you are having an emergency so we can handle the problem immediately.

New patients who are **late greater than 15 minutes** will not be seen and **must** be rescheduled to allow enough time for a full history and physical exam.

If you have any questions, do not hesitate to discuss it with me.

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HOSPITAL FOR SPECIAL SURGERY

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BILLING/COLLECTION POLICY

Please be informed that Dr. Berman is a participating provider with the following insurance plans **onlv**: Aetna (except *Medicare Advantage* plans - HMO, PPO, etc), Blue Cross/Blue Shield (PPO/EPO, Indemnity Plans *onlv),* Cigna, Medicare (Part B), Oxford, United Healthcare. If the doctor *does not participate* with your insurance plan, *payment is expected at the time of service* unless other arrangements have been made in advance with the office.

Co-pays, deductibles and payment for services rendered are expected at the time of service. You will be given an encounter form that includes the procedure code and diagnosis to submit to your insurance carrier. We accept cash, check and credit cards (Visa, MasterCard and American Express).

We will automatically submit claims to Aetna, BCBS, Cigna, Medicare, Oxford and United Healthcare.

We have been advised that some insurance companies are now imposing in-network deductibles for certain services rendered. You may receive a statement from our office for additional payment even though you may have paid your co-pay at the time of service.

If required by your insurance policy, you will be responsible for obtaining a referral from your primary care physician. Dr. Berman's provider numbers are as follows:

Aetna - 3245708 (HMO); 7052477 (PPO)
Cigna - 1183404
Oxford - P2948302
United Healthcare - 2333927
NPI - 1477516581

If you have any questions, please do not hesitate to call the office at 212.774.7501.

Thank you. We appreciate your cooperation.

PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY
535 East 70th Street NEW YORK, NY 10021

MEDICAL RECORD NUMBER **(FOR OFFICE USE ONLY)**

DATE OF VISIT

HOSPITAL PHYSICIAN

LEGAL ID TYPE ❑ DRIVER'S LIC. ❑ PASSPORT ❑ BIRTH CERT. ❑ SSN ❑ GREEN CARD ❑ OTHER

PATIENT'S FULL NAME (Last, First, MI.)					DATE OF BIRTH	BIRTH PLACE
STREET ADDRESS				CITY	STATE	ZIP CODE
COUNTRY	HOME PHONE	SEX	RACE	MARITAL STATUS	SOC. SEC. NUMBER	CELL PHONE (if applicable)

TEMPORARY ADDRESS #1

E - MAIL ADDRESS

ARE YOU CURRENTLY RESIDING IN A SKILLED NURSING FACILITY OR INPATIENT REHAB FACILITY? ❑ YES ❑ NO

IF YES, PROVIDE NAME OF FACILITY

SKILLED NURSING FACILITY/REHAB FACILITY ADDRESS

PHONE NUMBER OF FACILITY

HAVE YOU EVER BEEN TO HSS FOR A DOCTOR OR HOSPITAL VISIT ? ❑ YES ❑ NO

IF SO, WHAT DOCTOR AND WHEN WERE YOU SEEN?

EMPLOYMENT (If full-time student provide information on school)

PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT	RETIREMENT DATE
EMPLOYER ADDRESS (no., stret, city, state, zip code)		EMP PHONE	E - MAIL ADDRESS

GUARANTOR (The person responsible for the bill)

❑ SELF ❑ SPOUSE ❑ PARENT/GUARDIAN ❑ OTHER (If guarantor other than self, provide person's information below)

EMERGENCY CONTACT

PERSON # 1 FULL NAME (Complete this section for Spouse, Parent, Legal Guardian, etc.)		RELATIONSHIP TO PATIENT		DATE OF BIRTH
ADDRESS (no., street, apt#, city, state, zip code)		SEX	HOME PHONE	SOC. SEC. NUMBER
EMPLOYER	OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)				EMP PHONE

PERSON # 2 FULL NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
ADDRESS (no., street, apt#, city, state, zip code)	SEX	HOME/WORK/CELL PHONE

PHYSICIAN INFORMATION

REFERRING PHYSICIAN & ADDRESS	OTHER PHYSICIAN INFORMATION

ACCIDENT RELATED INFORMATION

IF YOUR SERVICE IS RELATED TO AN INJURY OR ACCIDENT - HOW DID YOUR INJURY OCCUR?

DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION (IF RELATED TO WORKER'S COMP OR NO FAULT, PLEASE ENTER WC OR NF IN PRIMARY INS. SPACE BELOW, AND ENTER HEALTH/MEDICAL COVERAGE IN SECONDARY INS. SPACE BELOW)

PRIMARY INSURANCE

INSURANCE COMPANY NAME	PHONE NUMBER
INSURANCE COMPANY ADDRESS	NAME OF CLAIMS ADJUSTER (if applicable)

POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)	WCB CASE NUMBER (if applicable)

SECONDARY INSURANCE

INSURANCE COMPANY NAME	PHONE NUMBER	
INSURANCE COMPANY ADDRESS	POLICY NUMBER	GROUP/PLAN NUMBER

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT - I certify that the information given by me is correct. I understand that this information is entered into a database, and I hereby authorize the sharing of such information with Hospital affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to the Hospital and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered.

MEDICARE PATIENTS - I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services and a 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment terms under Hospital policies.

EFFECTIVE DATE - These statements shall be effective from the date of the signature below until December 31 of the current year, unless you notify HSS otherwise in writing at the address written above.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

HOSPITAL FOR SPECIAL SURGERY

Authorization for Release of Health Information
(Request for Records)

Patient's Name _____ Date of Birth: _____

I, or my authorized representative, request that health information regarding my care and treatment be released to Jessica R. Berman, MD:

Health Provider/Entity to release this information:

Name of Person/Facility: _____

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

Fax Number: _____

Information to be disclosed: *(Please check all that apply)*

☐ All medical information

☐ Office Notes ☐ Lab Reports ☐ Cardiology Reports

☐ Consultation Reports ☐ Radiology Reports ☐ Operative Reports

☐ Other: _____

Reason for release of information:

☐ At request of individual

☐ Other: _____

Date or event on which this authorization will expire: _____

♦ PLEASE FAX INFORMATION TO 212.606.1577 ♦

By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. It is noted that when my protected health information is disclosed to people or entities that are not required to abide by federal or state privacy laws, those people/entities may re-disclose my information to others and use my information without being subject to penalties under those laws.

I have the right to revoke this authorization at any time by writing to the provider. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned up my authorization of this disclosure.

By signing below, I acknowledge that I have read and accept all of the above.

_____ _____

Signature of Patient or Personal Representative Date Signed

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

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RHEUMATOLOGY NEW PATIENT QUESTIONNAIRE

Name: _____ Age: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____ S.S.N.: _____

Home Phone: _____ Sex: ☐ Male ☐ Female

Work Phone: _____ Email: _____

DOCTORS:

Primary Care (name, full address, phone, fax):

_____

_____

_____

Specialists - list all doctors you see regularly for particular problems (name, full address, phone, fax):

_____

_____

_____

_____

_____

_____

RHEUMATIC DISEASE HISTORY:

In brief what is problem you are here for today or have been diagnosed with already?

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:
Please list any problems you currently have or have seen a doctor for in the past:

PAST SURGERIES:
Please list any surgeries or procedures you have had in the past:

MEDICATIONS:
Please list all, including **over-the counter drugs,** the doses and how often you take them. List vitamins and **herbal or alternative treatments** as well:

Pain Medications:
Please list any pain medications (non-steroidals, Tylenol, etc) that you have used in the past and whether or not they worked for you or why you stopped them:

_____

_____

_____

_____

_____

_____

ALLERGIES:
List drug name and the type of reaction (rash, difficulty breathing, etc), and any food or other allergies:

_____

_____

_____

_____

_____

_____

Do you have a history of any of the following?

	Yes	No	Unsure	Comments
weight loss				
decreased appetite				
fever/night sweats				
tiredness/fatigue				
headaches				
seizures				
stroke				
dry eyes				
change in vision				
ulcer/sores in the mouth				
drv mouth				
thyroid problem				
diabetes (high blood sugar)				
high blood pressure				
chest pain				
raoid heartbeat/palpitations				
heart failure				
blocked arteries (coronary artery disease)				

Do you have a history of any of the following?

	Yes	No	Unsure	Comments
shortness of breath				
pneumonia				
asthma or emphysema				
lung blood clot (pulmonary embolus)				
heartburn				
stomach pain				
ulcer				
history of hepatitis				
liver problems				
diarrhea				
constipation				
blood in stool				
urinary problem				
urine infection				
prostate problem				
protein in the urine				
kidney problem				
kidney stone				
menstrual irregularities				
miscarriage				
edema/swelling in the feet				
numbness/tingling				
color changes in hands/feet in cold				
anemia/low blood counts				
low platelets				
abnormal bleeding				
leg blood clot/DVT				
seasonal allergies				
sinus problems				
hair loss				
psoriasis				
eczema				
other type of rash or hives				
new skin tightness or thickening				
rash caused by sun				
nail problems				

PERSONAL HISTORY:

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Widow ☐ Divorced ☐ Separated

Name of Spouse/Partner: _____

Do you have any children? ☐ Yes ☐ No

Names and ages:

_____

_____

_____

Smoking:

Current smoker: ☐ Yes ☐ No

If yes, how much and how often?_____

Previous smoking: ☐ Yes ☐ No

If yes, when did you stop? _____

Alcohol Use:

How often and what form (beer, wine, etc)?

_____

_____

Exercise:

Please describe how much and how often:

_____

_____

Family History:

	Alive	Deceased	Age	Problems
Mother	☐	☐	_____	_____
Father	☐	☐	_____	_____
Brothers or Sisters				
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____

Does anyone in your family have a history of the following problems? (If yes, please say how they are related to you):

Rheumatoid Arthritis	☐ Yes	☐ No	_____
Lupus	☐ Yes	☐ No	_____
Autoimmune disease	☐ Yes	☐ No	_____
Thyroid disease	☐ Yes	☐ No	_____
Bone loss/osteoporosis	☐ Yes	☐ No	_____

Health Maintenance:

For women:

When was your last pap smear? _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No Date:_____

When was your last mammogram? _____

For men:

Have you ever had an abnormal prostate test (PSA)? ☐ Yes ☐ No Date:_____

For both:

When was the last time your stool was checked for blood (rectal)? Date: _____

Have you ever had a colonoscopy? ☐ Yes ☐ No Date:_____

Have you ever had a chest x-ray? ☐ Yes ☐ No Date:_____

Have you ever had a tuberculosis test? ☐ Yes ☐ No Date:_____

Have you ever had a hepatitis test? ☐ Yes ☐ No Date:_____

☐ Hep B ☐ Hep C

Have you ever been tested for HIV? ☐ Yes ☐ No Date:_____

Please explain any abnormal results:

_____

_____

_____

Please write down any other concerns you would like to bring up during the visit:

_____

_____

_____

_____

_____

_____