



Central Park  
Physical Medicine and  
Rehabilitation, P.C.

Joyce Goldenberg, M.D.  
Diplomate American Board of Physical Medicine and Rehabilitation

# Central Park Physical Medicine and Rehabilitation Registration Sheet

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ MI \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone (Res) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Phone (Work) \_\_\_\_\_ Ext. \_\_\_\_\_ email \_\_\_\_\_

## Emergency Contact Information

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

## Employment Information

Company \_\_\_\_\_

Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Employer  
Address \_\_\_\_\_

## Primary Insurance Information

Company \_\_\_\_\_ Claim# \_\_\_\_\_

Group # \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Policy ID No. \_\_\_\_\_ Policy Holder \_\_\_\_\_

Attorney  
Attorney \_\_\_\_\_ Date of  
Accident \_\_\_\_\_

Telephone \_\_\_\_\_ Attorney  
Fax \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA****[This form has been approved by the New York State Department of Health]**

Patient Name ,	Date of Birth	Social Security Number
Patient Address ,		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: <b>Central Park Park Medicine/Joyce Goldenberg , MD 265 W 37th Street Suite 660 New York NY 10018</b>
8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:	
<input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____	
<input type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.	
<input type="checkbox"/> Other: _____	Include: <i>(Indicate by Initialing)</i>
	_____ <b>Alcohol/Drug Treatment</b>
	_____ <b>Mental Health Information</b>
	_____ <b>HIV-Related Information</b>

**Authorization to Discuss Health Information**

- (b) ☐ By initialing here \_\_\_\_\_ I authorize \_\_\_\_\_  
Initials Name of individual health care provider  
to discuss my health information with my attorney, or a governmental agency, listed here:  
\_\_\_\_\_  
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

\_\_\_\_\_  
Signature of patient or representative authorized by law.

Date: \_\_\_\_\_

\* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use  
of the HIPAA-compliant Authorization Form to  
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as “at the conclusion of my court case” or provide a specific date amount of time, such as “3 years from this date”.

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.



## Central Park Physical Medicine and Rehabilitation Financial Policy (No Fault)

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we will require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor. Please be advised that P.O. Boxes are not acceptable and that we must have a valid street address for each patient.

As soon as a case number has been opened by the insurance carrier, we will normally accept assignment of benefits as payment in full for no fault cases. However, a lien must be signed by you.

### **THE FOLLOWING, CONDITIONS WILL CAUSE YOU TO BE PERSONALLY RESPONSIBLE FOR YOUR BILL:**

1. All cancellations or "No-Shows" will be billed at \$50 per session.
2. If you receive checks directly from the insurance company, those checks must be turned over to Central Park Physical Medicine and Rehabilitation, P.C. (CPPMR)
3. You must notify CPPM&R immediately of any Independent Medical Examinations (IME) required by the insurance carrier and of their notices of decision. Failure to appear for an IME will cause you to be personally responsible for the bills.
4. You must attend any Independent Medical Examinations (IME) or Examination Under Oath (EUO) that are required by the insurance carrier.
5. If you were the driver involved in a Driving While Under the Influence (DWI) motor vehicle accident, your insurance carrier will not pay for any of the bills.
6. Excessive cancellation or "No-Shows" of physical therapy sessions will cause CPPM & R to cancel future appointments.
7. An application of benefits must be filed within 30 days of the accident with the insurance company or your entire case will be denied. Please confirm that the carrier actually has the application of benefits 30 days after the accident.

Under most insurance company's rules the Doctor must do a follow-up examination every 30 days. Failing to comply with this requirement is not our responsibility.

### **Business Matters**

Please be advised that the Doctors' time is extremely limited and due to that, the Doctors cannot get involved in business matters. Therefore, all business matters must be addressed to the office staff who will be more than glad to answer any questions concerning billing, payments, appointments and other financial matters.

All telephone consults with you, family member or physician regarding your condition will be charged to your account at \$50.00 per call.



## Central Park Physical Medicine and Rehabilitation Financial Policy (No Fault)

Please note that all personal forms that you require Dr. Goldenberg to complete carry a \$15. 00 charge per form.

### **Cancellation Notice**

Please be aware that patients cancelling appointments with less than 24 hours notice will be charged \$50.00 per session. This charge is not reimbursable by insurance and therefore you will be personally responsible for this amount. If there are excessive “no shows” we will terminate your treatment.

Thank you for your anticipated cooperation.

I authorize payment of medical benefits directly to Joyce Goldenberg, M.D.

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

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

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

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

I \_\_\_\_\_, (“Assignor”) hereby assign to  
(Print patient’s name)

**CENTRAL PARK PHYSICAL MEDICINE & REHABILITATION, P.C.**, (“Assignee”) all rights privileges and  
(Health care provider name)

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 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 \_\_\_\_\_, not withstanding any other agreement to the contrary  
(Print accident date)

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 DOLLORS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

\_\_\_\_\_  
(Print name of Patient)

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_

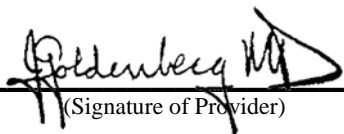
\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address of Patient)

**CENTRAL PARK PHYSICAL MEDICINE & REHABILITATION, P.C.**

(Health care provider name)

**DR. JOYCE GOLDENBERG, MD**  
(Print name of Provider)

  
\_\_\_\_\_  
(Signature of Provider)

**2 WEST 86 STREET**

\_\_\_\_\_  
(Date of signature)

**NEW YORK, NY 10024**  
(Address of Provider)



## **LIEN ASSIGNMENT AGREEMENT**

I, \_\_\_\_\_,

residing at \_\_\_\_\_  
hereby enter into the following agreement with Central Park Physical Medicine and Rehabilitation, P.C., hereinafter known as “the Provider” in order to guarantee payment for services rendered by the Provider to me for an accident on \_\_\_\_\_. I understand that I am directly and fully responsible to the Provider for all medical bills for services rendered to me. I understand that I am directly and fully responsible to the Provider for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay **all** remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond on behalf of the Provider as often as may be necessary for any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge responsibility for the repayment of all outstanding balances. I further direct that my attorney shall not subsequently dispute these amounts and will contact this office to arrange for full payment at the time a settlement, trial or motion proceed becomes ready for disbursement.

To the extent applicable, I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of No-Fault benefits and result in the reliance on this lien for reimbursement purposes.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided to the extent applicable. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the Provider for the submission of the aforementioned insurance claim as applicable.

I hereby give and grant this lien on my case to the Provider against any and all proceeds of any settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf that may be paid to me or my attorney as a result of the injuries for which I have been treated. I grant the Provider the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse Central Park Physical Medicine and Rehabilitation, P.C. for services rendered to me and towards all outstanding balances.

I hereby **direct** and **authorize** direct payment to the Provider, such sums as may be due and owing for medical services rendered to me. I further direct my attorney to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse the Provider for services rendered to me towards all outstanding balances. At the request in writing by either the patient or the attorney, a billing statement will be provided by the Provider detailing the services rendered, dates of service and amounts outstanding so that all balances can be addressed prior to disbursement.

I understand that this document may not be rescinded and that my attorney shall not honor any such rescission. I hereby instruct that in the event another attorney is substituted in my case, the new attorney shall honor this lien as inherent to the settlement, judgment, verdict or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I agree to authorize my attorney, on demand, to provide the status of such litigation to the Provider. Furthermore, I direct my attorney to contact the Provider prior to disbursement of any funds to ascertain any outstanding balances due and owing to Central Park Physical Medicine and Rehabilitation, P.C.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

The undersigned, being the attorney of record for the above-named patient, does hereby agree to observe all the terms of the lien and agrees to withhold such sums from any settlement, judgment as may be necessary to adequately protect the Provider. The attorney accepts notice that a portion of their clients personal injury claim has been assigned to the Provider and agrees to disburse the funds to the Provider in order to satisfy any outstanding lien or to act as an escrow agent prior to disbursing any proceeds. The attorney further acknowledges that he will be liable to client's assignees if he pays out money in disregard of this lien.

The attorney agrees that if another attorney is substituted, this lien will be forwarded to the substituting attorney and the Provider will be notified in writing of the same within thirty days. The attorney shall bear all costs, including, but not limited to, reasonable legal fees associated with enforcement of this lien if necessary.

\_\_\_\_\_  
Signature of Attorney/Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Attorney's Stamp



**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS**

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW,  
PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

- IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.  
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).  
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*
--------------------------------

1. YOUR NAME	2. PHONE NOS.      HOME      BUSINESS		
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.	
6. DATE AND TIME OF ACCIDENT <div style="text-align: right;">A.M. P.M.</div>	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE		
8. BRIEF DESCRIPTION OF ACCIDENT			
9. DESCRIBE YOUR INJURY			

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME      MAKE      YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS,      ☐ A TRUCK, ☐ AN AUTOMOBILE,  
☐ OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PEDESTRIAN?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO**

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: \_\_\_\_\_

HOSPITAL'S NAME AND ADDRESS: \_\_\_\_\_

14. AMOUNT OF HEALTH  
BILLS TO DATE:

\$ \_\_\_\_\_

15. WILL YOU HAVE MORE HEALTH  
TREATMENT(S)?

YES NO

☐ ☐

16. AT THE TIME OF YOUR ACCIDENT WERE  
YOU IN THE COURSE OF YOUR  
EMPLOYMENT?

YES NO

☐ ☐

17. DID YOU LOSE TIME  
FROM WORK?

YES NO

☐ ☐

DATE ABSENCE FROM  
WORK BEGAN:

HAVE YOU RETURNED TO  
WORK?

YES NO

☐ ☐

IF YES, DATE RETURNED TO WORK:

\_\_\_\_\_

AMOUNT OF TIME LOST FROM WORK:

\_\_\_\_\_

18. WHAT ARE YOUR GROSS AVERAGE  
WEEKLY EARNINGS?

NUMBER OF DAYS YOU WORK  
PER WEEK:

NUMBER OF HOURS YOU WORK  
PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO  
ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS  
UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	<input type="checkbox"/>	<input type="checkbox"/>
WORKERS' COMPENSATION?	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE  
APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

.....  
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

\_\_\_\_\_  
NAME (PRINT OR TYPE)

\_\_\_\_\_  
SOCIAL SECURITY NO.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

.....  
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

\_\_\_\_\_  
NAME (PRINT OR TYPE)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-2 (Rev 1/2004)

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## Central Park Physical Medicine and Rehabilitation Financial Policy (No Fault)

Thank you for choosing Central Park Physical Medicine & Rehabilitation [CPPM&R] as your health care provider. We are committed to your treatment being successful. Our Financial Policy requires you to read and sign this financial agreement prior to any treatment. Please understand that payment of your bill is in not only required but is considered a part of your treatment.

All patients must complete our Information and Insurance form before seeing the doctor. Please be advised that P.O. Boxes are not accepted and a valid street address is required for each patient.

Upon processing your No Fault application your insurance carrier will assign you a case number. In the interim, CPPM&R will normally accept a signed Assignment of Benefits and Lien (both in this packet) as a promissory payment.

### THE FOLLOWING CONDITIONS WILL CAUSE YOU TO BE PERSONALLY RESPONSIBLE FOR YOUR BILL:

1. A No-Fault application of benefits must be filed with the insurance company within 30 days of the accident. Failure to submit the application timely will result in your entire case being denied. It is your responsibility to confirm that the carrier has the application of benefits before the 30-day threshold expires.
2. All cancellations with out a 24 hour prior notice will be considered a "No-Shows" and will be billed at \$50 per session. *Note: Excessive cancellation or "No-Shows" of physical therapy sessions will cause CPPM&R to cancel future appointments.*
2. Any insurance checks for treatments issued and received by you from the insurance company which are not turned over to (CPPM&R).
3. Failure to attend any Independent Medical Examinations (IME) or Examination Under Oath (EUO) that are required by the insurance carrier. CPPM&R expects prompt notification as soon as you are scheduled for an IME or EUO.
4. Note: The law states that if you were the driver involved in a motor vehicle accident and deemed as Driving While Under the Influence (DWI), your insurance carrier will not pay for treatment.

Thank you for your anticipated cooperation.

I authorize payment of medical benefits directly to Joyce Goldenberg, M.D.

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

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_



## Central Park Physical Medicine and Rehabilitation Lien Letter Agreement

I \_\_\_\_\_, (patient name) residing at \_\_\_\_\_ (address) hereby enter into the following agreement with \_\_\_\_\_ (Company), hereinafter known as “the provider” in order to guarantee payment for services rendered by “the provider” to me. I understand that I am directly and fully responsible to “the provider” for all medical bills for services rendered to me. I understand that I am directly and fully responsible to “the provider” for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier as applicable. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with “the provider” as often as may be necessary for any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge responsibility for the repayment of all outstanding balances. I further direct that my attorney shall not subsequently dispute these amounts and will contact this office to arrange for full payment at the time a settlement, trial or motion proceed becomes ready for disbursement.

To the extent applicable, I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may, at the election of the medical provider, serve to revoke any assignment of No-Fault benefits. The patient herein further acknowledges their responsibility to file a timely notice of claim to the applicable insurance carrier and that any subsequent No Fault claim denied based on the failure to provide a timely notice, at the election of the provider, may result in recovery efforts in reliance of this lien.

The Provider agrees to seek compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided and to the extent applicable. The patient shall provide all necessary insurance information, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of No-Fault benefits and result in the reliance on this lien for reimbursement purposes.

If patient provides insurance information for a No-Fault claim that indicates a third-party administrator and does not provide the name of the underlying insurer, Provider will submit the claim to the named entity but Patient agrees that any assignment of benefits may be revoked retroactively by provider who will revert to this Lien for payment. Patient directs his attorney not to dispute any such revocation in favor of the lien where an entity, such as a third-party administrator cannot be pursued in Court for payment based on jurisdictional issues.

I hereby give and grant this lien on my case to “the provider” against any and all proceeds of any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me or my ATTORNEY as a result of the injuries for which I have been treated. I grant “the provider” the aforesaid lien against such sums of the aforesaid settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse “the provider” for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby direct and authorize direct payment to “the provider”, such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor the aforesaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse “the provider” for services rendered to me towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such rescission. I hereby instruct that in the event another ATTORNEY is substituted in my case, I direct the substituted attorney to provide the incoming ATTORNEY with a copy of this lien and that I direct any incoming ATTORNEY to honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct and authorize my attorney, on demand, to provide the status of such litigation to “the provider” or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact “the provider” or the attorney representing the provider prior to disbursement of any funds to ascertain any outstanding balances due to \_\_\_\_\_.

\_\_\_\_\_  
Patient Signature

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

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date:



## **Central Park Physical Medicine and Rehabilitation HYPERTENSION DISCLAIMER ATTESTATION**

**Hypertension or elevated blood pressure is a dangerous and insidious condition that can lead to stroke, heart attack, heart failure and kidney failure. It is a silent killer. Therefore, I understand that it is my responsibility to have this condition treated by my primary care doctor or hospital emergency department. My failure to have this condition treated and the consequences thereof are solely my responsibility and do not hold liable the doctors and therapists treating me for my accident.**

\_\_\_\_\_  
Patient's Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness's Signature:

\_\_\_\_\_  
Date:

### **ACKNOWLEDGMENT OF OBTAINING PRIMARY CARE FOR MEDICAL CONDITIONS NOT RELATED TO MY NO-FAULT ACCIDENT**

I am aware of my responsibility to seek medical treatment from my primary care physician for all conditions not related to the injuries sustained in my accident. If I fail to properly seek medical care and follow medical advice for afflictions or conditions not related to my accident, I am solely responsible.

\_\_\_\_\_  
Patient's Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness's signature:

\_\_\_\_\_  
Date:



## Central Park Physical Medicine and Rehabilitation ATTACHMENT D

*Effective Date: April 14, 2003*

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility, and how I may obtain access to and control this information:

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Date

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

The patient refused to sign despite good faith efforts

The patient was unaccompanied and not alert and oriented

The patient was unaccompanied and needed emergency care

Other, (explain): \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Employee Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Acknowledgement subsequently obtained, (see above).





# Central Park Physical Medicine and Rehabilitation, P.C.

## Joyce Goldenberg, M.D.

### SUMMARY-NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### Our Pledge to Protect your Privacy:

Central Park Physical Medicine & Rehabilitation, P.C. is committed to protecting the privacy of your medical information. So that we can best meet your needs, we share your medical information with all the healthcare providers involved in your care. Only to the extent necessary, we also use and share your information to conduct our business operation, to collect payment for the services we provide to you and to comply with the laws that govern healthcare. We will not use or disclose your information for any other purpose without your permission.

#### Examples of how we may use and disclose your health information:

- To bill and receive payment for the treatment and services you receive;
- For functions necessary to run Central Park Physical Medicine & Rehabilitation, P.C. and to assure that our patients receive quality care;
- To provide only demographic information to our development office for purposes of Marketing.
- To support our research mission as an academic medical center with approval of our Institutional Review Board (IRB);
- For workers' compensation or similar programs;
- For required public health activities (e.g., reporting abuse or adverse reactions to medications);
- For healthcare oversight (e.g., to the New York State Department of Health);
- For law enforcement in certain limited circumstances;
- To a coroner, medical examiner or funeral director as required by law;
- For organ procurement or transplantation, if you are a potential donor.

### NOTICE OF PRIVACY PRACTICES

**We Must** use and disclose your health information to provide information;

- To you or someone who has the legal right to act for your (your personal representative)
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

**We have** the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information;

- **For Payment** and to process claims for health care services you receive.
- **For treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your pharmacist or your doctor to suggest a disease management\_ or wellness program that could help improve your health,
- **To provide Information an Health Related Programs or Products** such as alternative medical treatments and programs or about health related product and services.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with our providers who provide medical care to you.
- **Business Associates.** We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an insurance company or law firm, or a risk management organization in order to obtain professional advice about how to manage risk and legal liability, including insurance or legal claims. We may also share your health information with an accounting firm in order to obtain advice on legal compliance. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

**We may use** or disclose your health information for the following purposes under limited circumstance;

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.

- **For Public Health Activities** such as reporting disease outbreak.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

If none of the above reasons applies, then we must get your written authorization to use or disclose your health information. If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In New York State, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact our Medical Records department at (212) 447-0300.

## **WHAT ARE YOUR RIGHTS**

- **You Have The Right To See and Obtain** a copy of your medical and billing records, subject to some special requirements for substance and alcohol abuse, genetic, mental health and HIV-related data. You may also receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information. We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days if the information is located in our facility and within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request. If you request a copy of the information, we may charge a fee, as permitted by law, for the costs of copying, mailing or other supplies we use to fulfill your request. The fee must generally be paid before or at the time we give the copies to you.
- **You Have The Right To Ask To Restrict** certain uses or disclosures of your medical information; Please note that while we will be to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.
- **You Have The Right To Receive An Accounting** of disclosures of your medical information made by us during the six years prior to your request. This accounting will not include disclosures of information; (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **To add an addendum** to your medical record. Information we maintain about you may be amended if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information. You Have The Right To Ask To Receive Confidential Communications of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address)
- **You Have The Right To Receive A Copy Of This Notice.** We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. A copy of our current notice will always be posted in our reception area. You will also be able to obtain your own copies by accessing our website at [www.stoppingpain.com](http://www.stoppingpain.com), or calling our office and asking for one at the time of your next visit: !!!r' **Street Location: (212) 447-0300, Br'** **Street Location: (212) 787-7994.**

## **EXERCISING YOUR RIGHTS**

- **Contacting Us.** If you have any questions about this notice or want to exercise any of your rights, please call (212) 447-0300.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address;

**Central Park Physical Medicine & Rehabilitation, P.C., 200 Madison Avenue, @36th St., New York, NY 10016**

### **Incidental Disclosures**

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.



**Thank you for choosing**

**Central Park Physical Medicine and Rehabilitation**

**please the "Submit" button below**

**For Further information feel free to contact us at**

**Tel: 212.659.4390**