NYC PAIN SPECIALISTS

a Trusted Pain Physician Company

K A R A N J O HA R, M.D.

P: 212.371.8460
F: 212.537.7303

Karan Johar, M.D.
Furqan Tejani, M.D.
Pierre Alex Casthely, M.D.
Rene Hilderbrand, MSPAS, D.O.
Roy Berenholtz, M.D.
Julissa Cruz, M.D.
Julia Zaitsev, R.N.

Lenox Hill Pain Innovation & Research Center
30 Central Park South (at Fifth Avenue)
New York, New York, 10019

Greenwich Village Pain Institute & Surgery Pavilion
95 University Place (at 12th Street)
New York, New York, 10003

New York Joint and Bone – Orthopedic Sports Medicine Urgent Care
41 East 11th Street (at Broadway)
New York, New York, 10003

REGISTRATION FORM - MAJOR MEDICAL

Date: _____

Last Name: _____ First and Middle Name: _____ Social Security #: _____

Birthdate: _____ Age: _____ Sex: F M Marital Status: M S D W

Home Address: _____ City: _____ State: _____ Zip: _____
*Does the above address, match the address on your State Identification Card? Y N

Home/Work Phone: _____ Mobile Phone: _____

Email Address: _____ Employer/Occupation: _____

PRIMARY INSURANCE
Insurance Name: _____ Type: PPO POS EPO HMO Note Sure
Policy Holder's Name: _____ Relation: _____ Policy Holder's DOB: _____
Policy # _____ Group # _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

SECONDARY INSURANCE
Insurance Name: _____ Type: PPO POS EPO HMO Note Sure
Policy Holder's Name: _____ Relation: _____ Policy Holder's DOB: _____
Policy # _____ Group # _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

The given information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that in the event that insurance benefits are paid directly to me, I will forward payment to KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS with the understanding that if to do so within 90 days, it may be determined that the services of a collection fees and/ costs associated with the collection of said past due balance(s) is mine. I also authorize KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS or insurance company to release any information required to process my claims.

_____ _____

Patient/ Guardian Signature ***Date***

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Release of Information:
I hereby authorize the physician to release any information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company (ies).

_____ _____
Patient/ Guardian Signature ***Date***

EMERGENCY CONTACT: Name: _____ Relation: _____ Phone: _____

REFERRING PHYSICIAN: Doctor's Name: _____ City, State: _____

PRIMARY/FAMILY PHYSICIAN: Doctor's Name: _____ City, State: _____

PREFERRED PHARMACY: KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS e-prescribes non-narcotic medications as mandated by Federal Laws. In order to comply, we need accurate pharmacy information. All controlled substances must be obtained at the same pharmacy, where possible, and **must** be filled in **The State of NY.** Should you need to change pharmacies arise, our office must be informed ahead of time. Please provide your pharmacy's information where you expect to fill any prescriptions written by the practitioners at KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS.

Pharmacy Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Patients Rights and Responsibilities:
I hereby acknowledge that I have read the Patient Rights and Responsibilities. I have read the Patient Rights as posted during my check-in. A printed copy is included in the *Practice Policies* form and is available to me should I request it.

_____ _____
Patient/ Guardian Signature ***Date***

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Assignment of Benefits

As a courtesy to the patient and their families, KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS does submit claims to many third party payers. I request that payment of authorized Medicare or private benefits be made to KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS for any covered services furnished by KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS. If my insurance carrier pays me directly, I agree to forward all funds to KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS within 10 business days.

Disclosure of Information

I understand that my medical records and billing information are made and retained by KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS and are accessible to KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS personnel, who may use disclosed medical information for KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS operations and functions and to any other health care personnel involved in my continuum of care for this admission.

Release of Records

I authorize KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS to release to any governmental health care program
and its agents, or to any private insurance company or its agents any information needed to determine my benefits payable for KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS.
I hereby authorize my attending physicians to release all medical records pertaining to my healthcare information to KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS.

Acknowledgement of Notice of Private Practice

A complete description of how my medical information will be used and disclosed KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS has been KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS's NOTICE OF PRIVATE PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this consent form. If I have any questions, I know to contact the Compliance Officer whose information is provided to me in the Notice of Private Practices.

Consent for Care Treatment

I, the undersigned, do hereby agree and give consent to KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS to furnish medical care and treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition.

Patient Name: _____ Date of Birth_____

_____ _____

Patient/ Guardian Signature ***Date***

_____ _____

Witness Signature ***Date***

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. **Payment and Explanation of Benefits for services rendered to me should be sent directly to the above healthcare provider directly or if my policy prohibits payment to said health care provider then the check should be made out to me care of the above health care provider and send to the address shown on the medical claim form.** I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature _____ Print _____ Date _____

If unable to sign, or are a minor Signature of Guardian/Representative _____ Print _____
Relationship to Patient _____

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Agreement to Pay for Physician Services

I, _____, agree to pay Dr. Karan Johar, KARAN JOHAR, MD, PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC for the physician services he rendered to me on the dates shown below.

Date(s) of Service: All dates where service was rendered or as specified below.

_____
_____
_____

Total Amount Due or Past Date to be paid: **1st of each month**

It is understood that I, agree to make payments in the amount of up to 25% to 100% per month of the outstanding balance, due on the 1st of each month for the period of months it may take to settle my past due balance, until payment of said past due balance is made in full. Payments will be made by cash or check. I may ask Dr. Johar to charge the credit card below for the monthly payment, but agree that if I do I will incur an additional credit card processing fee of 5% each time the credit card is used for payment. I further agree to accept responsibility to pay . Karan Johar, KARAN JOHAR, MD, PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC any and all fees incurred if my check bounces or my credit card is declined.

Credit Card Type: Visa / MasterCard / American Express / Discover

Credit Card Number: _____ **Expiration Date:** _____ **CVV:** _____

Name as appears on card: _____

It is understood that if I miss any payments, . Karan Johar, KARAN JOHAR, MD, PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC has my agreement, and the right, to charge the full balance of my debt to the credit card as shown above, transfer my debt to a collection agency, or seek restitution in court. If my account is transferred to a collection agency or legal proceeding are undertaken in court to recover the amount I owe to . Karan Johar, KARAN JOHAR, MD, PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC, I further agree to pay any and all additional costs associated with said collection agency fees or legal and court costs in addition to the balance of my debt.

_____
Name of Patient (print or type)

_____
STREET

_____
City, State, Zip+4

Phone: _____

X_____
Patient Signature

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TELECOMMUNICATIONS POLICY:

I_____ hereby give KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS and all its affiliate entities permission to leave messages regarding:

- Medical Information _____
- Billing Information _____

On my answering machine at the following numbers:

- _____
- _____

I, _____ , hereby voluntarily provide my email and cell telephone number to The KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS.

I agree to permit KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS and their authorized representative to communicate with me by email and text message with respect to confirming my follow up/procedure appointments, medical claims submitted to my insurance company as well as any balances not covered by insurance, coinsurance, deductibles or any other balance deemed patient responsibility.

To be clear, I am consenting to communication by email as required by 15 USC 7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such case, I will notify the practice in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to email communication in writing to The KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS. There are no hardware or software requirements needed to receive email communication from The KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS or their authorized representatives other than an active email account obtained from a vendor that provides such email accounts.

The KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS will not sell, share, or rent your email address or any other personal information collected on this consent.

Email address: _____

Cell phone #: _____

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature _____ Print _____ Date _____

If unable to sign, or are a minor Signature of Guardian/Representative _____Print _____

Relationship to Patient _____

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Disclosure of Physician Affiliation

NOTICE TO PATIENTS:

Please carefully review the information contained in this notice.

Pursuant to the new Emergency Medical Services and No Surprise Bill law, in order to allow you to make a fully informed decision about your health care, the physicians of KARAN JOHAR, MD, PLLC OR LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC OR SUBSIDIARY AFFILIATED PHYSICIANS (the "Practice") would like to advise you that we participate with the following health plans: (i) Medicare, accepted as non-participating provider(s) only; (ii) Workers Compensation, and (iii) No Fault Insurance.

Also, we are affiliated with the following hospital: Lenox Hill Hospital.

Please note that the amount or estimated amount for your procedure or services is available upon request. If you have any questions concerning this notice, please feel free to ask your physician or any representative of our office. We welcome you as a patient and value our relationship with you.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS

BY: _____ DATE: _____

(Patient/Patient Representative Signature)

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HIPAA AUTHORIZATION FORM

Patient's Full Name _____ **Patient's Social Security Number/Medical Record Number** _____

Address _____ **Patient's Date of Birth** _____

City, State Zip Code _____ **Patient's Telephone Number** _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   _____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name _____

   Address _____

   City, State Zip Code _____
3. The specific information that should be disclosed is (please give dates of service if possible):
   _____
   _____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____ .
7. This authorization expires on _____, 200___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**
R, if applicable – _____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

_____	_____	_____
Received	**Processed By**	**Log #**

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