Burke Medical Group
On the campus of Burke Rehabilitation Hospital
785 Mamaroneck Avenue, Bldg #8-Outpatient Services-2nd Fl.
White Plains, NY 10605 P:914-597-2332

Directions:

From George Washington Bridge: Take the Henry Hudson Pkwy North to the Cross County Pkwy East to Hutchinson River Pkwy North. Exit 23 North (Mamaroneck Ave). Proceed on Mamaroneck Avenue for 5 traffic lights. Make a right onto Heatherbloom Rd. Entrance to Burke is immediately on left.
OR
Take I-95 North to Hutchinson River Pkwy North. Exit 23 North (Mamaroneck Ave). Proceed on Mamaroneck Avenue for 5 traffic lights. Make a right onto Heatherbloom Rd. Entrance to Burke is immediately on left

From the Tappan Zee Bridge or Northern New York: NY Thruway, Taconic Stae Pkwy or Route 9 to Route 287 East(Cross Westchester Expwy) to Exit 8W Bloomingdale Road. Make a left at the first light(Westchester Mall). Proceed on Bloomingdale Road which becomes Mamaroneck Avenue. The traffic light after Bryant Avenue make left onto Heatherbloom Rd and an immediate left into Burke Rhabilitation Hospital. Follow the road all the way to the end. We are located in Bldg 8, 2nd floor.

From New Jersey: Garden State Parkway to New York State Thruway to TappanZee Bridge. Follow directions from Tappan Zee Bridge.

From New York City: Hutchinson River Pkwy North. Exit 23 North (Mamaroneck Ave). Proceed on Mamaroneck Avenue for 5 traffic lights. Make a right onto Heatherbloom Rd. Entrance to Burke is immediately on left.
OR
New England Thruway: (I-95 North) to Exit 18B (Mamaroneck Avenue) Proceed on Mamaroneck Avenue for 5 traffic lights. Make a right onto Heatherbloom Rd. Entrance to Burke is immediately on left.

From Long Island: Take the Whitestone Bridge to Hutchinson River Pkwy North. Exit 23 North (Mamaroneck Ave). Proceed on Mamaroneck Avenue for 5 traffic lights. Make a right onto Heatherbloom Rd. Entrance to Burke is immediately on left.

From Connecticut: 1-95 South to I-287 West. Exit on to Hutchinson River Pkwy South Exit 23 North (Mamaroneck Ave). Proceed on Mamaroneck Avenue for 5 traffic lights. Make a right onto Heatherbloom Rd. Entrance to Burke is immediately on left.
OR
Merrit Parkway or I-684 South: To Hutchinson River Pkwy South Exit 23 North (Mamaroneck Ave). Proceed on Mamaroneck Avenue for 5 traffic lights. Make a right onto Heatherbloom Rd. Entrance to Burke is immediately on left.

****Co-payment is due at the time of your visit. Check or cash only****

PATIENT REGISTRATION FORM

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

MEDICAL RECORD NUMBER (FOR OFFICE USE ONLY)

PATIENT VISIT

ATTENDING DOCTOR: Dr. Gulotta

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, WHICH DOCTOR & 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., street, city, state, zip code) | EMP PHONE | E - MAIL ADDRESS

GUARANTOR (Insurance policyholder / 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

MEDICAL DETAIL

REASON FOR VISIT OR CHIEF COMPLAINT | ALLERGIES

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

DATE OF INJURY | TIME OF INJURY | PLACE OF INJURY

REFERRING PHYSICIAN & ADDRESS

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 _____

Shoulder Surgery and Sports Medicine

Name: _____ **Date:** _____

Date of birth: _____ **Age:** _____

Address: _____ **Telephone:** _____

_____

Email Address: _____

Occupation: _____

Referring doctor (if any): _____

Referring doctor's address: _____

_____

Why are you seeing Dr. Gulotta?

_____

_____

How long has this problem existed? _____

Is the problem a result of: ____ sports injury ____ work injury ____ accident

____ fall ____ lifting ____ pulling

Other (please describe): _____

What have you done for this problem to date?

Medicine (ie, Tylenol, Motrin, etc.): _____

Physical therapy: _____

Injections (steroid shot): _____

Surgery: _____

What type of exercise/sports do you do? _____

Do you smoke? _____ # of packs? _____

Do you drink? _____ # of drinks? _____ day/week/mo

Do you have a history of substance abuse? _____

All information in this Worksheet is **Confidential.**

Shoulder Surgery and Sports Medicine

Medical History: Are you currently having or have you had problems with:

	YES	NO	Type
• Asthma/ lungs	____	____	_____
• High blood pressure	____	____	_____
• Heart disease	____	____	_____
• Digestion	____	____	_____
• Bleeding problems	____	____	_____
• High cholesterol	____	____	_____
• Immune deficiency	____	____	_____
• Difficulty urinating	____	____	_____
• Cancer	____	____	_____
• Diabetes	____	____	_____
• Sleep Apnea	____	____	_____
• Other (Please list)	_____		

Any family members with similar orthopaedic history or experiences?

_____

_____

Do you take any medications? Please list:

_____

_____

Previous surgery:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Do you have any allergies to medications?

Medicine: _____ Reaction: _____

_____ Reaction: _____

Other allergies (type): _____

All information in this Worksheet is **Confidential.**

Lawrence V. Gulotta, MD

523 East 72nd Street, 7th Floor
New York, NY 10021
(646) 797-8735

Cancellation Policy for Surgery

In an effort to serve our patients better we have instituted a cancellation policy for scheduled surgery dates.

Scheduling surgery is a time consuming and complicated process, and the office understands that it is very disruptive to patient's normal lives. Likewise, when surgery is indicated, the office invests a considerable amount of time and effort beforehand, to ensure that the day of surgery goes as smoothly as possible. Ahead of your surgery, the office commits many hours of work to ensure that all aspects of your care are prepared for- including, but not limited to: pre-certification and follow up with your insurance plan, coordination of your care with related caregivers (including other physicians when indicated, allied health professionals, and anesthesiologists), and post-operative care in the form of rehabilitation preparation.

From time to time, extenuating circumstances cause a surgery to be canceled. However, in situations when the patient electively cancels a procedure within 10 days of the scheduled surgery, **a non-refundable cancellation fee of $500 will be charged to the patient.**

If your surgery is cancelled for a medical reason this charge does not apply. Please keep this in mind when scheduling your surgery date.

I,_____ have received and reviewed the surgery cancellation policy of Dr. Lawrence V. Gulotta. I hereby accept and agree to adhere to the above policy.

_____

Patient Signature or Parent/Guardian (if patient is a minor)

_____

Date

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff,
Residents, and Fellows

As your treating physician and as a member of the Medical Staff of Hospital for Special Surgery (HSS), I would like you to know that I have a financial relationship with the following orthopedic/biomedical device company whose products I may use, or prescribe, for you in your care at HSS. The following will provide you with information about my financial relationship with this company:

I am a consultant for, and a Speaker's Bureau participant with, Biomet, Inc. for which I receive compensation for my time.

I DO NOT RECEIVE ANY PAYMENTS FROM THIS COMPANY FOR USE OF ITS PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with me, you may contact Scott Rodeo, MD, Co-Chief of Service, (212-606-1513), the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

Signature_____
Patient/Parent/Guardian/Health Care Agent **Date**

Print Name_____
Patient/Parent/Guardian/Health Care Agent

_____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD

April 14, 2003

Medical Record Number _____

ACKNOWLEDGMENT OF RECEIPT

By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____

Signature of Patient or Patient's Personal Representative

_____

Print Name of Patient or Patient's Personal Representative

_____

Description of Personal Representative's Authority

_____

Date

If you have any questions about this notice or would like further information, please contact the office manager.

For Office Use Only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

_____

_____

_____