HOSPITAL FOR SPECIAL SURGERY WHERE THE WORLD COMES TO GET BACK IN THE GAME

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****

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION FORM
HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)		PREFERRED NAME	DATE OF BIRTH	SOC. SEC. NUMBER
SEX ASSIGNED AT BIRTH ❑ FEMALE ❑ MALE ❑ INTERSEX	SEX LISTED WITH HEALTH INSURANCE ❑ FEMALE ❑ MALE	WHAT IS YOUR GENDER IDENTITY? ❑ SAME AS SEX LISTED WITH INSURANCE ❑ OTHER:_____	PREFERRED PRONOUNS ❑She/Her ❑ Ze/Hir ❑He/His/Him	
PERMANENT STREET ADDRESS		CITY	STATE	ZIP CODE
COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS ❑MYCHART ❑ DISCHARGE INSTRUCTIONS ❑ DECLINE	
TEMPORARY ADDRESS (IF APPLICABLE)		CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY? ❑ YES ❑ NO ❑UNKNOWN ❑ DECLINE	RACE	ADDITIONAL RACE	ETHNICITY
FURTHER DESCRIPTION OF ETHNICITY # 1	FURTHER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH ❑ VERY WELL ❑ WELL ❑ NOT WELL ❑ NOT AT ALL ❑ DECLINED ❑ UNAVAILABLE	
WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?		IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?	
WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ❑ YES ❑NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ❑ YES ❑ NO	
MARITAL STATUS	VISUALLY IMPAIRED? ❑ YES ❑NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS	

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? ❑ YES ❑ NO	NOTIFY PCP OF RESULTS? ❑ ALL ❑ ABNORMAL ❑ NONE	
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE			
PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT	RETIREMENT DATE	
EMPLOYER ADDRESS (no., stret, city, state, zip code)			EMPLOYER PHONE	

EMERGENCY CONTACT

FULL NAME CONTACT #1		ADDRESS (no., street, apt#, city, state, zip code)			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO
FULL NAME CONTACT #2		ADDRESS			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION DOWNTIME FORM
HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The person responsible for the bill)

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? ❑ YES ❑ NO	INJURED BODY PART: ❑ RIGHT ❑ LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

TERTIARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

WORKER'S COMPENSATION/NO FAULT INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

New Patient Questionnaire

Sports Medicine and Shoulder

HOSPITAL FOR SPECIAL SURGERY

Height:	Weight:	Age:

Chief Complaint

What is the reason for your visit? _____

_____

_____

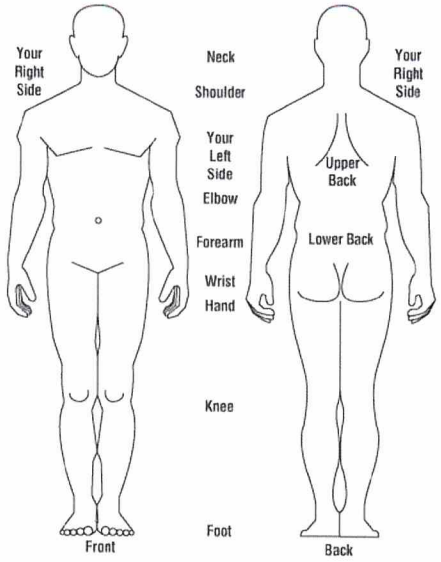
Please describe your symptoms:

Swelling	Stiffness	Locking	Instability
Giving Away	Numbness	Weakness	Tingling
Other:			

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Please mark on the body diagram where you are experiencing pain:



When did this condition start? _____

Please explain how this condition started: _____

_____

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you participate in any sports? _____

Level of play (please select):

Professional College High School Recreational

Have you had to modify your activities? Yes No

Are you still able to play sports/exercise? Yes No

Have you had or tried any of the following (please select and describe)?

Type	Date Range	Location/Results	Effective?
Acupuncture Treatment			Yes No
Anti-Inflammatory Medications			Yes No
Chiropractic Treatment			Yes No
Injections			Yes No
Physical Therapy			Yes No
MRI			
CT			
X-Ray			
Other:			Yes No

Name: _____

Are you currently on any blood thinners? _____

Do you currently have a MRSA Infection? Yes No

Have you had Deep Vein Thrombosis (DVT)? Yes No

Have you had a Pulmonary Embolism (PE)? Yes No

Have you ever had any problems with anesthesia? Yes No Problem: _____

Have you ever had complications from prior surgery? Yes No Problem: _____

Have you had surgery for this same condition before? Yes No

Do you think you may be pregnant at this time (women)? Yes No

Have you received the pneumonia vaccine? Yes No

If yes, date? _____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No

If yes, date? _____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Referring Physician: _____ Phone Number: _____

Please list the physicians that have treated you previously for this problem:

Physician: _____ Specialty: _____ Phone Number: _____

Physician: _____ Specialty: _____ Phone Number: _____

Name: _____

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Medical History

Please select all previous or ongoing medical issues:			
Anemia	Crohn's Disease/Colitis	Irregular Heartbeat	Sleep Apnea
Asthma	Diabetes	Kidney Disease	Stroke
Atrial Fibrillation	Emphysema	Lupus	Thyroid Disease
Bleeding Disorder	Glaucoma	Lyme Disease	Tuberculosis
Blood Clot/Phlebitis	Gout	Osteoporosis	Ulcers
Bronchitis	Heart Attack	Peripheral Vascular Disease (PVD)	Urinary Problems
Cancer	Hepatitis/Liver Disease	Pneumonia	Varicose Veins
Cataracts	High Blood Pressure	Productive Sputum	Others:
Congestive Heart Failure (CHF)	HIV	Rheumatoid Arthritis	
COPD	IBS	Shingles	

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Name: _____

Family History

Are there any illnesses that run in the family?

Anesthesia Problems	Yes	No	Relation: _____
Autoimmune Disease	Yes	No	Relation: _____
Arthritis	Yes	No	Relation: _____
Cancer	Yes	No	Relation: _____
Diabetes	Yes	No	Relation: _____
Heart Disease	Yes	No	Relation: _____
High Blood Pressure	Yes	No	Relation: _____
Lupus	Yes	No	Relation: _____
Osteoporosis	Yes	No	Relation: _____
Pulmonary Disease	Yes	No	Relation: _____
Stroke	Yes	No	Relation: _____
Other: _____			Relation: _____

Social History

1. Are you a tobacco user? Yes No
2. Do you consume alcohol? Yes No

   If yes (women): more than 7 drinks per week, or more than 3 drinks per occasion? Yes No

   If yes (men): more than 14 drinks per week, or more than 4 drinks per occasion? Yes No

Name: _____

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	Eyes	ENT	Cardiovascular
Weight gain	Corrective lenses	Headache	Chest pain
Weight loss	Blurred/Double vision	Sore throat	Palpitations
Night sweats	Eye Pain	Nose bleeds	Fainting
Fever	Redness	Ringing in ears	Murmurs
Chills	Watering	Earaches	
Fatigue			
None	None	None	None

Respiratory	Gastrointestinal	Genitourinary	Musculoskeletal
Short of breath	Heartburn	Frequent urination	Joint pains
Wheezing	Nausea	Difficult urination	Swelling
Cough	Vomiting	Painful urination	Instability
Tightness	Constipation	Flank pain	Stiffness
Snoring	Diarrhea	Bleeding	Redness
	Bloody stools		Heat
None	None	None	Muscle pains

Skin	Neurologic	Psychiatric	Hematologic/Lymphatic
Bumps/Nodules	Numbness/Tingling	Nervousness	Easy bleeding
Poor healing	Unsteady walking	Anxiety	Bruising
Rash	Dizziness	Depression	
Itching	Tremors	Hallucinations	
Redness	Seizures		
Hives			
None	None	None	None

Endocrine	Environmental Allergies	Other
Excessive thirst	Pollen	
Excessive urination	Dust Mites	
Heat intolerance	Pets/Animals	
Cold intolerance	Mold/Mildew	
None	None	

Name: _____

Effective Date: April 14, 2003
Revision Date: September 23, 2013

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at Hospital for Special Surgery. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Hospital and its medical staff and affiliated health care providers when providing health care services for our Hospital. Our Notice will be posted in the main entrance area of the Hospital at 535 East 70th Street, New York, New York and in other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu, calling Health Information Management at (212) 606-1254, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by the Hospital, and how I may obtain access to and control this information. I also acknowledge and understand special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and/or disclosure of my health information as described in this Notice, including to treat me and arrange for my medical care, to seek and receive payment for services given me, and for the business operations of the Hospital and its staff.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or 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 Privacy Officer at (212) 774-7500.

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

_____

_____

_____

Lawrence V. Gulotta, MD

523 East 72nd Street, 6th 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

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. 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

Medicare Protocol Effective January 1, 2016

Effective January 1st, 2016, our new Medicare status will be "Non-Participating Provider." Not a lot will actually change for you. We will still be happy to provide medical care to you, however, we will ask you to pay at the time of service. You will then be reimbursed from Medicare directly. This is how the process works:

1. You will be charged a Medicare limited charge rate which you will need to pay at the time of service. We will provide you with a receipt.
2. We will then bill Medicare on your behalf and Medicare will send payment directly to you in the mail, and then forward the information to your secondary insurance.
3. Your hospital stay and necessary medical testing such as hospital charges, laboratory tests and x-rays, will be billed directly to Medicare. This is exactly the same as it is now.

As an **example,** if you are seen for new patient consultation you may be charged approximately $206.83 at the time of the encounter. Medicare and your secondary insurance will then reimburse you directly.

Another **example**: for a follow up visit with injection you may be billed approximately $90.88 at the time of the encounter. Medicare and your secondary insurance will then reimburse you $63.22.

If you are having a shoulder replacement you may be billed $1918.49 prior to the surgery. Medicare and your secondary insurance will then reimburse you DIRECTLY, and you would be responsible for difference. The hospital charges will be submitted to your insurance from the hospital directly. Nothing will change regarding the hospital charges.

I have read and agree to the above stated changes to Dr. Gulotta's Medicare participation effective January 1, 2016.

_____

Patient Signature & date

HOSPITAL FOR SPECIAL SURGERY

GENERAL CONSENT/ PERMISSION FOR TREATMENT FINANCIAL AGREEMENT (OUTPATIENT)

I authorize and consent to performance upon _____
(*Insert "me" or Name of Patient*)
by Hospital for Special Surgery (HSS) and its staff of such physical examinations, diagnostic imaging procedures (such as x-rays, CT scans, and/or magnetic resonance imaging (MRI)), laboratory tests, and other non-invasive diagnostic and therapeutic procedures and/or treatments, as my/the patient's physician or others on HSS's medical staff consider to be necessary or appropriate for the purpose of diagnostic and/or treatment of my/the patient's condition.

I understand that for each procedure/treatment the following will be explained to and discussed with me/the patient: the nature, intended purpose, anticipated benefits, material risks, and possible complications of such procedure/treatment; the alternative procedures/treatments if such procedure/treatment is not performed; and the probable consequences if such procedure/treatment or alternative procedures/treatments are not performed.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the procedure/treatment may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with medical procedures and treatments that can cause adverse consequences not ordinarily anticipated in advance.

I consent to the diagnostic study by HSS of any blood, urine or other bodily fluids, stool specimens, or tissues that are obtained in the performance of such procedures/treatments, and to the disposal of such fluids/ specimens/tissues by HSS in accordance with its customary practice. I further grant permission for HSS to use such fluids/specimens/tissues for medical, scientific and/or educational purposes.

I consent to the photographing, videotaping, televising, or other observation of the procedures/treatments as HSS or its surgeon(s)/physician(s) may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/patient's identity will remain confidential.

I consent to the presence during the procedures/treatments of a visitor or visitors, which may include any visiting physician(s) and/or vendor representative(s) whose presence has been requested by the above named surgeon(s)/ physician(s). I understand that the visitor(s) will at all times be under the supervision and direction of the above named surgeon(s)/physician(s) and other HSS personnel, and subject to all relevant HSS policies and procedures.

I understand that information about me/the patient will be disclosed as required by applicable law, including reporting mandated by the federal, state and local governments to oversight agencies such as Centers for Disease Control and Prevention, the New York State Department of Health, and the New York City Department of Health and Mental Hygiene. Examples of such mandated reporting include reporting of suspected or confirmed communicable diseases, child abuse, firearm wounds, and certain knife wounds and burns.

I understand that HSS does not provide all of the medical services that I/the patient could ever possibly require, and that in the event I/the patient need treatment not provided by HSS during my/the patient's hospitalization at HSS, it may become necessary to transfer me/the patient to another hospital that provides the medical services required by me/the patient (including, for patients at HSS's main campus, New York-Presbyterian Hospital). I hereby consent to the transfer to such other hospital of me/the patient for such treatment when HSS determines that transfer is medically necessary or advisable.

I understand that HSS will electronically transmit prescriptions to my pharmacy (ePrescribing) as required by New York law. I also understand that in connection with ePrescribing, HSS and members of its Medical Staff will obtain medication history (information about the medications I/the patient are currently taking or have taken within the past year) for purposes of coordinating my/the patient's treatment. I hereby consent to ePrescribing by HSS and members of its Medical Staff, including obtaining my medication history and making it part of the HSS medical record.

FINANCIAL AGREEMENT

Assignment of Benefits

I assign, transfer and set over to HSS and members of its Medical Staff sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, and others who are financially liable for hospitalization and medical care of me/the above-named patient by HSS and its Medical Staff.

If I am entitled to Medicare benefits, 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; 20% co-insurance on all ancillary services. I also understand that when Medicare is deemed that secondary insurance responsible for payment of my medical care, I will be financially classified under HSS's policies and will follow payment terms under said policies.

Authorization for Release of Information

I authorize and direct HSS and those members of its Medical Staff who have treated me/the above-named patient to release to government agencies, insurance carriers, and others who are financially liable for hospitalization and medical care of me/the above-named patient, all information needed to substantiate and obtain payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Guarantee of Hospital Charges

I agree to be responsible for payment in full of the charges for all hospital services and other medical care rendered to me/the above-named patient for this period of care. I understand that even if I have/the patient has domestic or international health insurance coverage accepted by HSS, I will be responsible for payment in full of unpaid balances after insurance company payment to HSS, to the full extent permitted under federal, state and local laws. I understand that my responsibility also includes payment for charges not ordinarily covered by health insurance, such as private room charges.

I confirm that I have read and fully understand this General Consent/Permission for Treatment & Financial Agreement, that I have been given the opportunity to ask questions and have had my questions answered satisfactorily, and that I am eligible to give this consent and agreement. I further confirm that I understand that I have the right to revoke this consent, or any part of it, at any time during my/the patient's treatment by HSS.

Signature of Patient/Parent/Guardian/Health Care Agent/Other Surrogate _____ **Date** _____ **Time** _____

Relationship to Patient _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this General Consent/Permission for Treatment & Financial Agreement.

Signature of Witness _____ **Date** _____ **Time** _____

HOSPITAL
FOR
SPECIAL
SURGERY

Acknowledgement

Date:

Patient Name:

MR#

I am aware that Dr. Lawrence Gulotta Orthopaedic Surgeon will not testify, or make himself available for depositions in any cases including but not limited to Workers Compensation, No Fault or Lawsuits.

I agree that upon request my medical records will be provided, requests can be made by fax at 646-797-8726

I agree to the terms and conditions.

Patient Name:_____ Date:_____

HOSPITAL FOR SPECIAL SURGERY

Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions.

Please complete the information below:

Patient Name: _____

Preferred Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Alternate Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to HSS laboratory.**

LabCorp	
Quest Labs	
HSS Lab	
Other External Location	

Please provide name of external location: _____

HOSPITAL FOR SPECIAL SURGERY

WHERE THE WORLD COMES TO GET BACK IN THE GAME

I, _____, hereby authorize Dr. Gulotta and staff

to discuss my medical care with _____

who is my _____.

I also give permission to release my medical records to my

_____.

_____ _____

Patient Signature Date

Dr. Lawrence Gulotta

535 East 70th Street

NY, NY 10021

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: _____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1
(print) _____

Name of Witness 2
(print) _____

Signature _____ Signature _____

Address _____ Address _____

_____ _____

State of New York
Department of Health