westchester
SPINE & BRAIN
surgery

Bennie W. Chiles III, MD, FAANS, FACS
Board Certified, American Board of Neurological Surgery
Fellow, American College of Surgeons

280 North Central Avenue, Suite 235 Hartsdale, NY 10530
Tel. (914)332-0396 Fax (914)468-8895

Bennie W. Chiles III, M.D., F.A.C.S.
Board Certified, American Board of Neurological Surgery
Fellow, American College of Surgeons

Dear Patient,

Your neurosurgical consultation appointment has been made with our office. Please follow the instructions below in order to make your visit with us as productive as possible.

1. Complete registration forms and bring with you on the day of your appointment.
2. Bring one form of photo identification.
3. **YOU MUST BRING YOUR MRI OR CT SCAN FILMS / DISC ALONG WITH THE WRITTEN REPORT (if report not previously provided).**

The Surgeon is unable to make a complete diagnosis or properly recommend the appropriate treatment without viewing the films or C.D.'s and reports. It is necessary that you bring a "hard" copy of your MRI/CT Scan with you to your appointment. If you do not bring the films/disc, your appointment will be rescheduled.

INSURANCE:

1. Your insurance identification card will be necessary.
2. If your insurance requires a co-payment you will be responsible that copay amount at the time of your appointment.
3. For Workers' Compensation, complete insurance related forms in its entirety.

DIRECTIONS

1. If not enclosed, you may obtain directions to the office on our website at www.wsbsonline.com.
2. If travelling by GPS and "North Central Avenue" is not showing, you can use "Route 100" or "Central Park Avenue".
3. Public Transportation; Bee Line Bus #20. Hartsdale Train Station 1.2 miles south of office. White Plains Train Station 1.2 miles north of office.

****************************PLEASE NOTE ****************************

Due to the nature of this practice, if an emergency arises it may be necessary to cancel or reschedule patient appointments.

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Visit Date: ______________

Patient Name: ____
First Middle Last

Reason for visit:____

Sex (M/F/T): ____ Age: ___ Birthdate: __________ SS#: __________________ Marital Status: ______

Mailing address: ____

City: _______________________State: ______Zip: _________ Driver's license#/State:______________

Phone numbers: _____________________ _______________________ _______________________
Home **Work** **Cell**

Email address: ______________________________________

Employer: ____

____
Address City State Zip

Referring Physician

Name: ______________________________

Address: ____________________________

City/State/Zip: _______________________

Phone #: ___________________________

Primary Care Physician

Name: __________________________

Address: _________________________

City/State/Zip: ____________________

Phone #: _________________________

Emergency contact ____
Name Daytime Phone number Relationship to patient

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Participating Disclosure Form

Bennie W. Chiles III, M.D. is participating provider with the following Healthcare Plans:

MVP Health Care (in network with Essentials HMO and Medicaid Managed Plans ONLY)
Workers' Compensation (except Dept. of Labor, non-participating)
Automobile "No Fault" Insurance

Bennie W. Chiles III, M.D. is affiliated with the following Hospitals:

White Plains Hospital Center
Montefiore Hospital New Rochelle
Westchester Medical Center
St. John's Riverside Hospital
St. John's Riverside Hospital - Dobbs Ferry Pavilion
Stamford Hospital
New York- Presbyterian Lawrence Hospital

Acknowledgement of Receipt:

Print name: ____

Patient Signature: ______________________________ Date: ______________

Pharmacy:

Pharmacy name: ________________________ Store# if applicable: __________

Address: ____

City: ______________________ State: ___________ Zip code: __________

Telephone: (_____) __________________ Fax: (_____) ____________________

Our office complies with the NYS e-prescribe program. As a component of electronic prescribing, we require your consent to access your medication history from your pharmacy and/or the NYS Health Commerce System.

Patient Signature: ______________________________ Date: ____________

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WORKERS' COMPENSATION INFORMATION

Date of injury____/____/______ Injured site(s): ____________________________________

Have you ever had the same or a similar condition? _____________________________________

On the date of injury, what was your title or job description? ______________________________

How did accident happen? ____

Please list complaints, symptoms relative to your W/C injury: __________________________

____

____

Employer when injury occurred?:____
Address: ____
Telephone:(____)________________ Fax:(____)_________________

W/C Insurance Carrier*:________________________ Adjusters Name:______________________
Address:____
Telephone:(____)________________ ext. ________ Fax:(____)____________________
WCB #:____________________________ Carrier Case #:___________________________

Have you been hospitalized or are treating with another doctor for this injury? If yes, please give dates of hospitalization, and/or name and phone number of treating physician:

____

____

Are you currently working (circle)? YES NO Last Day Worked?: __________________

Current Documented Disability Status for Workers' Compensation (circle):
Total(100%) Marked(75%) Moderate(50%) Mild(25%)

Please list physician who made this disability determination:

____

Attorney Name, address, and phone number:

____

CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to HIPAA)

INSTRUCTIONS
To the Claimant: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers' Compensation Board, your employer's insurance carrier, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

IMPORTANT: Failure to execute this authorization may interfere with your ability to obtain workers' compensation benefits.

CLAIMANT'S NAME	CLAIMANT'S SOCIAL SECURITY NUMBER	CLAIMANT'S DATE OF BIRTH
LIST ALL WCB CASE NUMBER(S) AND CORRESPONDING DATE(S) OF ACCIDENT FOR WHICH YOU ARE GRANTING AUTHORIZATION		

I, ______________________________, hereby authorize my treating health provider,
Claimant's Name

Bennie W. Chiles III, M.D.______________________, to disclose the following described health information:
Health Provider's Name

____

____

____

This information can be disclosed to the following parties: *(check all that apply; give names and addresses, if known)*

- ☐ New York State Workers' Compensation Board
- ☐ My current/former employer ______________________________
- ☐ Workers' compensation insurance carrier(s) ______________________________
- ☐ Third-party administrator ______________________________
- ☐ My attorney/licensed representative ______________________________
- ☐ The Uninsured Employer's Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)
- ☐ Special Funds Conservation Committee (for cases under Section 25-a or 15-8 of the Workers' Compensation Law)

Section 25-a: If your claim is being reopened after being previously closed, the Special Fund for Reopened Cases may be responsible for paying your medical bills and lost wage benefits.

Section 15-8: If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer's insurance carrier after a period of time has elapsed.

Redisclosure: I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.
Expiration Date: This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes.

______________________________	______________________________	______________
Printed Name of Claimant or Legal Representative	Signature of Claimant or Legal Representative	Date

If Authorization signed by a legal representative on behalf of claimant, state relationship to claimant______________________________and basis for authority (e.g. claimant is a minor; patient is deceased and representative is the claimant in a workers' compensation proceeding or represents the estate) ______________________________

TO THE HEALTH PROVIDER: Keep the original of this Authorization on file. A copy must be given to the patient/claimant upon request.
DO **NOT** SEND TO THE NEW YORK STATE WORKERS' COMPENSATION BOARD.

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

	NAME	ADDRESS / APT. NO.
CLAIMANT		
EMPLOYER		
INSURANCE CARRIER		

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature____ Date __________________

Provider's Name and Address: Bennie W. Chiles III, MD

280 North Central Avenue, Suite 235 Hartsdale, NY 10530

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. Do not file with the Workers' Compensation Board. You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

Prescribed by Chair Workers' Compensation Board State of New York (www.wcb.state.ny.us)

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MEDICAL/SOCIAL HISTORY

Are there any serious medical problems that run in your family? Y_______ N_______

If Yes, please list: ____

List any prior major illness and/or injuries: ____

Right or Left Handed? _________Approximate Height? __________ Approximate Weight? _________

Smoker? ________ If Yes, How Much? ________Do You Drink? _______ If So, How Often? ________

Medical Marijuana use? YES NO
Circle one

Recreational Drug use? YES NO
Circle one

SURGICAL PROCEDURES	YEAR	COMPLICATIONS?

CURRENT MEDICATIONS	DOSE	FREQUENCY

LIST ALL ALLERGIES TO MEDICATION/MEDICAL MATERIAL (i.e., contrast dye, latex):

____

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE:

Patient Signature: ____Date: __________________

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