Sabrina Shue, MD, PLLC

Patient Information

Name: _____ M F Age: _____
Last, First, Middle (Circle One)

DOB: _____ SSN: _____ Single Married Divorced Separated Widowed

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Race: _____Ethnicity: _____Preferred Language: _____

Email: _____ Occupation: _____

Employer: _____ Address: _____

Insurance Information

Is this a Workman's Compensation case? Y or N Is this an Auto Injury case? Y or N

Primary Carrier: _____ ID#: _____ Group: _____

Name of Insured: _____ Relationship to Patient: Self Spouse Parent

Secondary Carrier: _____ ID#: _____ Group: _____

Name of Insured: _____ Relationship to Patient: Self Spouse Parent

Responsible Party's Name: _____ Relationship to Patient: Self Spouse Parent

Address (if different): _____ City: _____ State: ____ Zip: _____

Referral

Primary Care Physician (PCP): _____ Phone#: _____

Referring Physician: _____ Phone#: _____

How did you learn of our practice? _____

Emergency Contact

Name: _____ Phone: _____

Address: _____ Relationship: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Solutions Pain Management and/or my insurance company to release any information required for processing my claims including my private health information.

Signature of person filling out this form: _____ Date: _____

Sabrina Shue, MD, PLLC

General Agreement/Consent Form

General Information:

I request care from **Sabrina Shue, MD, PLLC** and it's physicians for treatment of my medical condition. This care may include medical tests, examinations, procedures, medications or any other treatments rendered necessary by my physician for my health condition. By signing this agreement I am consenting to the care listed above.

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for healthcare operations like quality reviews.

I have been informed that I may review the practice/clinics Notice of Privacy Practices (for a more complete description of uses of disclosures) before signing this consent form.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised copy at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s) set forward in the agreement amendment.

I also understand that I may revoke the consent at any time, by making a request in writing to the practice administrator, except for information that has been previously disclosed.

Patient Name: _____

Patient Signature: _____

Date: _____

*If signed by someone other than patient please disclose your relationship to the patient above.

10 Chester Avenue, 3rd Floor
White Plains, NY 10601
Phone (914) 227-9090 | Fax (914) 227-9095 |
www.shuemd.com

Sabrina Shue, MD, PLLC
Advanced Anesthesia Associates
Financial Policy for Patient Care Services

To help Advanced Solutions Pain Management to provide the most efficient and reasonable health care services, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have **accurate** and **complete** insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within 30 (thirty) days. If we receive duplicate payment from the insurance company, we will then prepare a refund for any overpayment and send it to you.

If you have insurance and we file with your carrier, we ask that you pay ahead of time on the balance which is your responsibility according to your plan, i.e., any deductible, co-payment and/or co-insurance amounts. For Medicare patients, we will wait until we have received payment and then bill the patient for any remaining balance due. Since we are not a party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within 30 (thirty) days.

For **Worker's Compensation** claims, it is our policy to bill your employer or the Worker's Compensation carrier for services rendered. If you are covered, we will accept the payment made by Worker's Compensation as payment in full. If Worker's Compensation denies payment or goes into litigation, the entire balance will become your responsibility and will be due within 10 (ten) days from the date of the denial. It is your responsibility to contact us with the name and address of your employer or the insurance company at the time the appointment is made and to provide the office with a copy of your Notice of Compensation Payable Letter from Worker's Compensation. **All insurance is verified prior to the patient's initial visit**.

If you do not have insurance and are not covered by Medicare, you will be considered a **"SELF PAY"** patient. Payment is due in full at the time of service. This assists us in cutting down on billing and operating expenses.

Patient "no shows" and cancellations are a tremendous loss for a practice. These events also deny other patients from receiving treatment in a timely manner. Please help our office reduce those losses by cancelling within 24 hours if you cannot keep your appointment. Failure to give notice 24 hours prior to your appointment will result in a fee to be paid by the patient as follows:

- **Office Appointment $25 fee**
- **Procedure/Surgical Appointment $50 fee**

We ask that you read this policy and aid us in keeping our costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to discuss any aspect of our financial policy.

To help in this policy we ask that you assist us by:

1. At your initial visit you will be asked to provide our office with one form of photo identification, your current insurance card(s) and to complete your patient demographic/registration forms in full.
2. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
3. Make payment at the time of service for the entire balance if you are a **"SELF PAY"** patient, or for the amount of any deductibles or co-pays that may be due. You may not be seen if you cannot settle your balance before your appointment time.
4. Co-pays and deductibles are due and expected at the time of your appointment. **There will be an additional $20 processing fee if you are unable to make your copayment at the time of your appointment.**
5. Discuss your account balance only with the check-out or business staff or contact the billing department of the hospital and /or physicians. Please do not discuss the financial aspects of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with the rest of the office staff on any account questions or problems you may have. If they cannot help you or answer your questions to your satisfaction, then please, do not hesitate to contact the office manager.
6. Managed Care Patients Only: Most managed care companies do not cover services that are not approved or arranged by a patient's primary care physician (PCP). If a referral from your PCP is required and Advanced Solutions Pain Management does not have one on file, I then agree to assume full financial responsibility for all charges incurred for the services provided to me that my insurance plan refuses to cover.
7. Collection Expenses: Should your account with this office be in default and is referred to an attorney or outside agency for collection, you will pay a reasonable collection expense of 35% of the outstanding balance, as well as any cost associated with the litigation.

_____ _____ _____

Patient Date Staff Signature Rev 04/15

Sabrina Shue, MD, PLLC
10 Chester Avenue, 3rd Floor
White Plains, NY 10601
Tel 914-227-9090
Fax 914-227-9095

Advanced Anesthesia Associates
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White Plains, NY 10601
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Billing Policies

To Patients:

Some or all of the services rendered by the physicians at Advanced Solutions Pain Management and Advanced Anesthesia Associates are considered out of network by your insurance company.

*For patients **with** out-of-network benefits*:

1. For your conveniences, we will bill your insurance for you, rather than expect you to pay the bill yourself. We will wait until your insurance make their payment rather than turn to you for payment. However, we may request your assistance in intervening with your insurance company in order to expedite payment and reduce your out of pocket expenses.

2. While we are working with your insurance company, you will receive billing statements from us periodically showing our progress in collecting your bill. Should you receive payment directly from your insurance company during this period, please forward the payment along with the Explanation of Benefit (EOB) statement to our office immediately so that we may correct your statement.

3. When your insurance has finished paying us, we are obligated by law to send you a bill for the balance. Should paying this bill present a financial hardship to you, please call our office and discuss this matter with our office manager or billing department at 914-227-9090. We do not want any of our patients to make an important medical decision based on their ability or inability to pay for the care they need.

*For patients **with no** out-of-network benefits:*

1. Payment for your service is expected at the time of your office visits. Should paying this bill present a financial hardship to you, please call our office and discuss this matter with our office manager or billing department at 914-227-9090. We do not want any of our patients to make an important medical decision based on their ability or inability to pay for the care they need.

Thank you for your cooperation.

I read and understood the above policies.

_____	_____	_____
Patient Name	Patient Signature	Date

Sabrina Shue, MD, PLLC
10 Chester Avenue, 3rd Floor
White Plains, NY 10601
Tel: 914-227-9090
Fax: 914-227-9095

Pharmacy Intake Form

First Name: _____ Last Name: _____

Date of Birth: _____

Name of Pharmacy: _____

Address of Pharmacy: _____City: _____

State: _____ Zip Code _____Tel#_____ Fax# _____

CURRENT MEDICATION REGIMENT

Medication Name	Dosage
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Allergies:

Please circle and list any other allergies you may have. Also state what kind of reaction you have?

No Known Allergies

I.V. Contrast Dye: _____ Iodine: _____

Shellfish: _____ Latex: _____

Other allergies you may have and the reaction to it?

- _____
- _____
- _____
- _____

Sabrina Shue, MD, PLLC

Workers' Comp Intake Form / No-Fault Intake

Is this a work-related Injury? Y or N Is this a No-fault Injury? Y or N

Name: _____ Date of Birth: _____

Insurance Carrier's Name: _____

Address of Carrier: _____

City: _____ State _____ Zip Code _____

Name of Employment at the time of injury: _____

Carrier Contact Name: _____

Claim#: _____WCB#/ Policy#:_____

Phone: ( ) _____Fax: ( ) _____

Address/Location where Injury occurred: _____

Date and Time of Accident/Injury: _____

Are you Currently Working? Y or N First day unable to work: _____

Workers' Comp Attorney/ No-Fault Attorney

Attorney's Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Phone#: _____ Fax#: _____

10 Chester Avenue, 3rd Floor White Plains, NY 10601

Phone: (914) 227-9090

Fax: (914-227-9095

Patient Name: _____ Date:_____

Dear patient, the following sets of questions are to help us identify problem areas that are important for your well being.

Are you 65 years old or older. (Yes, No)

Did you have a pneumonia (pneumococcal) vaccine shot: If YES, Date: Month_____, Year_____. If NO please make an appointment with your Primary Care Physician.

IF YOU ARE A FEMALE PATIENT 65 YEARS AND OLDER

Did you had **screening** for **osteoporosis**? (Yes, No)

If YES, Date: Month_____, Year_____. If NO, please make an appointment with your Primary Care Physician.

Did you have a drink containing alcohol in the past year?

- ☐ *Yes*
- ☐ *No*

If 'Yes' : How often did you have a drink containing alcohol in the past year?

- ☐ *Never (0 point)*
- ☐ *Monthly or less*
- ☐ *2 to 4 times a month*
- ☐ *2 to 3 times a week*
- ☐ *4 or more times a week*

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ *1 or 2 drinks*
- ☐ *3 or 4 drinks*
- ☐ *5 or 6 drinks*
- ☐ *7 to 9 drinks*
- ☐ *10 or more drinks*

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

- ☐ *Never*
- ☐ *Less than monthly*
- ☐ *Monthly*
- ☐ *Weekly*

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Are you a

- ☐ current smoker
- ☐ former smoker
- ☐ nonsmoker
- ☐ current every day smoker
- ☐ current some day smoker
- ☐ Smoker current status unknown
- ☐ unknown if ever smoked
- ☐ light tobacco smoker
- ☐ heavy tobacco smoker
- ☐ Uses tobacco in other forms

Additional Findings: Tobacco User

- ☐ Chain smoker
- ☐ Chews fine cut tobacco
- ☐ Chews loose leaf tobacco
- ☐ Chews plug tobacco

- [ ] Chews tobacco
- [ ] Chews twist tobacco
- [ ] Heavy cigarette smoker (20-39 cigs/day)
- [ ] Light cigarette smoker ((1-9 cigs/day)
- [ ] Moderate cigarette smoker (10-19 cigs/day)
- [ ] Pipe smoker
- [ ] Rolls own cigarettes
- [ ] Snuff user
- [ ] Trivial cigarette smoker (less than one cigarette/day)
- [ ] User of moist powdered tobacco
- [ ] Very heavy cigarette smoker (40+ cigs/day)

Additional Findings: Tobacco Non-User

- [ ] Aggressive non-smoker
- [ ] Current non-smoker
- [ ] Current non-smoker, but past smoking history unknown
- [ ] Does not use moist powdered tobacco
- [ ] Ex-cigar smoker
- [ ] Ex-cigarette smoker
- [ ] Ex-cigarette smoker amount unknown
- [ ] Ex-heavy cigarette smoker (20-30/day)
- [ ] Ex-light cigarette smoker (1-9/day)
- [ ] Ex-moderate cigarette smoker (10-19/day)
- [ ] Ex-pipe smoker
- [ ] Ex-trivial cigarette smoker (<1/day)
- [ ] Ex-user of moist powdered tobacco
- [ ] Ex-very heavy cigarette smoker (40+/day)
- [ ] Intolerant ex-smoker
- [ ] Intolerant non-smoker
- [ ] Never chewed tobacco
- [ ] Never used moist powdered tobacco
- [ ] Non-smoker for medical reasons

- [ ] Non-smoker for personal reasons
- [ ] Non-smoker for religious reasons
- [ ] Tolerant ex-smoker
- [ ] Tolerant non-smoker

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Acknowledgement of Receipt of Privacy Practices

Patient Name _____
Date of Birth _____

I have received or been offered Sabrina Shue, MD, PLLC Notice of Privacy Practices written in plain language, and have been given the opportunity to read and ask questions about the Notice. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

NOTE: Messages may be left for you on your answering machine or with a person who may answer your home / cell / work phone in regard to office questions, appointments and pre-certification authorization numbers.

I, _____(print patient name), give permission to the office and affiliates of Sabrina Shue, MD, PLLC, to leave a message at the following numbers provided.

Please provide at least one phone number:

☐	Yes	☐	No	Home #	_____
☐	Yes	☐	No	Answering Machine	_____
☐	Yes	☐	No	Work #	_____
☐	Yes	☐	No	Voice Mail #	_____
☐	Yes	☐	No	Cell #	_____

The office and affiliates of Sabrina Shue, MD, PLLC may release any of my medical information to the following people (i.e. spouse, children, siblings, etc.):

_____ _____
_____ _____
_____ _____

_____ _____
Signature of Patient or Authorized Signature (if over 18 years of age) Date

_____
Printed name of Patient or Authorized Signature
(if patient is under 18 years of age)

FOR FACILITY USE ONLY (For documentation of refusal to sing)
Sabrina Shue, MD, PLLC made the following good faith effort to obtain the above-referenced patient's written acknowledgement of receipt of the Notice of Privacy Practices:

_____
_____
Signature of Staff Member _____ Date _____