MANHATTAN
PAIN MEDICINE

Patient Registration

Name: _____ Pronouns: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone: _____ E-Mail: _____

Emergency Contact (Name/relation): _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy (Address): _____ Phone: _____

Who referred you to us? _____

Reason for visit: _____

What medical conditions do you have? ▫Headache ▫Autoimmune ▫Cardiac ▫ PTSD/Depression

_____

Do you have any drug allergies? No / _____

What surgeries have you had? (when/what for): _____

_____

Current Medication	Dose / Frequency	How long have you used this?	Helpful?	Side effects?

Additional medications may be included on the back of this form

Prior Medication	Dose / Frequency	How long did you use this?	Helpful?	Side effects?

Additional medications may be included on the back of this form

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Do any of your immediate family members have any medical conditions? (please list by relation)

▫Migraine ▫Rheumatoid Arthritis ▫Psoriasis ▫Lupus ▫Thyroid ▫Other

_____

Describe your type of work: _____

Caffeine intake? ▫Yes (cups/day) _____▫No

Nicotine intake? ▫Yes (packs/vape/day) _____ ▫No, but used to ▫No, never

Alcohol intake? ▫Yes (#/week) _____ ▫No, but used to ▫No, never

Recreational drug use? ▫Yes _____ ▫No, but used to ▫No, never

Prior military service? (Y / N)

Level of Education: _____

Height: _____ Weight: _____

Do you have any of the following? (please circle)

GENERAL: Fever/chills Weight gain/loss Fatigue Dizziness

SKIN: Rash Lumps Sores Itching Dryness Color change Changes in hair or nails

HEENT: Headache Nosebleeds Dry mouth Hoarseness Sinusitis Vertigo Vision changes

NECK: Lumps Goiter

BREASTS: Lumps Pain or discomfort Nipple discharge

CARDIOVASCULAR: Chest pain or discomfort Palpitations Lightheadedness/syncope

RESPIRATORY: Cough Phlegm Bloody cough Wheezing

GASTROINTESTINAL: Nausea/vomiting Diarrhea/constipation Bleeding Pain

URINARY: Frequency Loss of control Urgency Itching Bleeding Discharge Pain

GENITAL: Hernias Discharge Sores Pain

PERIPHERAL VASCULAR: Cold/clammy or Hot/sweaty extremities Loss of hair Swelling

MUSCULOSKELETAL: Joint stiffness/swelling Contractures Hypermobility

HEMATOLOGIC: Clotting disorder Easy bruising taking blood thinner

IMMUNOLOGIC: Multiple allergies Rash Food intolerance Immunodeficiency

NEUROLOGIC: Fainting/blackouts Seizures Tremors or involuntary movements Neuropathy

ENDOCRINE: Heat or cold intolerance Excessive sweating Excessive thirst or hunger

PSYCHIATRIC: Depression Anxiety Suicidal or Homicidal ideation PTSD

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E-mail Medical Communication Informed Consent

I am engaging in email communication with my physician realizing that, because there is no way to absolutely secure any electronic exchange of information, the probability of compromise of confidentiality of personal medical information is substantially increased compared to face-to-face information exchange. As such, email communication on personal medical matters should be as limited as possible and reserved for situations not practically allowing for face-to-face communication, but in which the failure to timely inform the patient or their agent on personal medical issues could significantly compromise the patient's best interests and outcome. No guarantee is made for the timely receipt of email communication, and no guarantee of response is made.

Notwithstanding the above, email communication should, as much as possible, avoid discussion of highly sensitive medical matters that could be, in the event of an information leak, deleterious personally or publicly to the patient and/or their agents. Such topics best avoided are medical disability, sexually transmitted diseases, substance abuse, psychiatric conditions, prognoses (medical outcomes), end-of-life conditions or prognostications, disclosure of demise of an individual, and any other matter that reason could suggest might result in unpredictable emotional distress or reaction in the recipient and possibly lead to behavior harmful to the recipient or others. In a word, remote communicating is a minimally controlled circumstance. Language used should be careful, deliberate, and avoid "emotionally charged" terms.

Email medical communication is a means of sharing information. It is not a substitute for face-to-face medical encounters, and cannot be used for urgent or emergency care needs. Habitual, ongoing use of email for communicating medical information is discouraged in the best interests of medical professionals and patients and their agents.

By signature, I indicate I have read the above content and policy of my healthcare provider and I agree to abide by the principles and spirit set forth in this document. I further understand the risks and limitations of transmission of medical information communication electronically, and so release from all and any liability my healthcare provider for any unauthorized disclosure or leak of such information inadvertently to parties outside the intended senders and recipients of such communications. I will not hold responsible the sender of medical information by email for any delays in receiving such communications and resulting harm from such delays. I am aware that when communicating from the workplace some companies consider email "at work company property", and such messages may be monitored and read by the company's officials. Furthermore, email sent to your home may be intercepted by others. Email sent to your doctor's office, though directed to a specific individual, may be read by someone other than the designated recipient since all incoming messages in a medical facility must be reviewed timely, including when a staff member is absent for any reason. Finally, communicating by email always exposes both parties to the risk of computer software virus invasion which can jeopardize and destroy databases and software. By signing this, I release from any liability for damage from computer viruses my healthcare providers and their staff.

I also release my healthcare provider with whom I am communicating voluntarily in medical matters by email from any adverse effects such information has on me or my agents that might have been otherwise avoided or lessened by exchange of such information in face-to-face encounters. Taking all of the above into consideration, I wish to engage in email communications regarding my personal medical information or that for which I am a responsible agent. I have had an opportunity to ask questions on all the aforementioned and provide my consent freely.

Email Address: _____

Name: _____ Signature: _____ Date: _____

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Advance Benefit Notice / Consent to Receive Out-of-Network Services

Manhattan Pain Medicine, PLLC, Manhattan Pain Medicine Doctor, PLLC, Manhattan Pain Medicine Provider, PLLC, Manhattan Pain Medicine Rehabilitation, PLLC, and their affiliated providers are not contracted with your insurance, and each provider's services are billed independently. We remain out-of-network so that we may provide a higher level of service for our patients, including shorter wait times, longer appointments, and direct access to the providers.

Our first goal is to deliver the highest quality and most appropriate care to provide for your best possible recovery. We will make every effort to help you understand your benefits and financial responsibilities as they are communicated to us by your insurance plan.

If you have out of network benefits, we will submit claims to your insurance on your behalf. Your financial cost share, depending on co-insurance and/or deductible, *may* be higher than with a contracted in-network provider. Billed charges for each provider are based on the usual and customary rates published at *http://FairHealthConsumer.org*

Any balance applied to deductible or co-insurance will be your responsibility. If your insurance denies a service or recalls any payment after the fact you will be financially responsible for that service according to the Self-Pay Fee Schedule.

Patients with insurance plans that reimburse them directly must leave a credit card on file. We will not charge any card without notification. Unexcused cancellations within 24 hours, no-shows, and tardiness of 20 minutes incur a $150 fee which is not covered by insurance.

By signing, **I have read and understood the above**, and waive my federal consumer protection rights under the No Surprises Act in order to receive out of network care, and I have received a **Good Faith Estimate** of what my out of pocket expense will be.

Name: _____ Signature: _____ Date: _____

A photocopy of this consent shall be as effective and valid as the original.

MANHATTAN
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Assignment of Benefits - ERISA Authorized Representative Form

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider(s) and the Providers' representatives (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan NAMING ME AS PLAINTIFF IN SUCH LAWSUITS AND ACTIONS IF NECESSARY (or me as guardian of the patient if the patient is a minor)
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and their authorized representatives by email.

I understand that Manhattan Pain Medicine PLLC, Manhattan Pain Medicine Doctor PLLC, Manhattan Pain Medicine Provider PLLC, Manhattan Pain Medicine Rehabilitation, PLLC and all providers are OUT-OF-NETWORK with my insurance.

Name: _____ Signature: _____ Date: _____

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

MANHATTAN
PAIN MEDICINE

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information, pursuant to 45 C.F.R. S 164.520. Please review it carefully.

1. OUR DUTIES

We are required by law to maintain the privacy of your Protected Health Information ("Protected Health Information"). We must also provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our Privacy practices in regard to Protected Health Information and make new privacy policies effective for all Protected Health Information that we maintain. We will provide you with a copy of any current privacy policy upon your written request, addressed to our Privacy Officer, at our current address.

2. YOUR COMPLAINTS

You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by sending a certified letter addressed to "Privacy Officer" at our current address, stating what Protected Health Information you believe has been used or disclosed improperly. You will not be retaliated against for making a complaint. For further information you may contact our Privacy Officer, at telephone number (646) 580-3538.

3. DESCRIPTION AND EXAMPLES OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Here are some examples of how we may use or disclose your Protected Health Information. In connection with treatment, we will, for example, allow a physician associated with us to use your medical history, symptoms, injuries or diseases to treat your current condition. In connection with payment, we will, for example, send your Protected Health Information to your insurer or to a federal program, such as Medicare, that pays for your treatment. This allows us to obtain payment for the services we rendered on your behalf. In connection with health care operations, we will for example, allow our auditors, consultants, or attorney's access to your Protected Health Information to determine if we billed you accurately for the services we provided to you.

4. USES AND DISCLOSURES WHICH REQUIRE YOUR WRITTEN AUTHORIZATION Uses and disclosures other than those involving treatment, payment, and health care operations, as well as those described in the following sections of this Notice, will only be made by obtaining a written authorization from you. You may revoke this authorization in writing at any time, except to the extent that we have taken action in reliance upon your authorization.

5. USES AND DISCLOSURES NOT REQUIRING YOUR WRITTEN AUTHORIZATION The privacy regulations give us the right to use and disclose your Protected Health Information if: (i) You are an inmate in a correctional institution; (ii) we have a direct or indirect treatment relationship with you, (iii) we are so required or authorized by law. The purposes for which we might use your Protected Health Information would be to carry out treatment, payment, and health care operations similar to those described in Paragraph I.

6. USES OF PROTECTED HEALTH INFORMATION TO CONTACT YOU

We may use your Protected Health Information to contact you regarding appointment reminders or to contact you with information about treatment alternatives or other health-related benefits and Services that, in our opinion, may be of interest to you. We may use your Protected Health Information to contact you in an effort to raise funds for our operations.

7. DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR BILLING PURPOSES We may disclose

your billing information to any person that calls our billing staff or agents the billing questions after we verify the identity of the person by requesting information such as your social security number or health plan number.

8. DISCLOSURES FOR DIRECTORY AND NOTIFICATION PURPOSES

If you are incapacitated or not present at the time, we may disclose your Protected Health Information (a) for use in a facility directory, (b) to notify family or other appropriate persons your location or condition, and (e) to inform family, friends or caregivers of information relevant to their involvement in your ease or payment for your treatment. If you are present and not incapacitated. We will make the above disclosures, as well as disclose any other information to anyone you have identified, only upon your signed consent, your verbal agreement, or the reasonable belief that you would not object to such disclosure(s).

9. NOTICE REGARDING ELECTRONIC MEDICAL RECORDS (EMR) AND BILLING SYSTEM

Our practice uses a cloud-based electronic medical record (EMR) and billing system. This system may involve third-party vendors and service providers. Please be aware that your medical and billing information is stored and transmitted electronically. Third parties may have access to certain information without the direct knowledge or control of this practice. Data maintained in these systems may be used for analysis, reporting, or other purposes that are not specifically disclosed to us, and may include use by your insurance company. While we take reasonable steps to protect your privacy in compliance with New York and federal law, we cannot guarantee how third parties engaged by the EMR or billing system may use or analyze your information.

10. INDIVIDUAL RIGHTS

(i) You may request us to restrict the uses and disclosures of your Protected Health Information , but we do not have to agree. (ii) You have the right to request that we communicate with you regarding your Protected Health Information in a confidential manner or Pursuant to an alternative means, such as by a sealed envelope rather than a postcard or by communicating to a specific phone number, or by sending mail to a specific address. We are required to accommodate all reasonable requests in this regard. (iii) You have the right to request that you be allowed to inspect and copy your Protected Health Information as long as it is kept as a designated record set, and as long as you pay in advance for the administrative time and costs to make arrangements to have the records inspected and copied. Certain records are exempt from inspection and cannot be inspected or copied, so each request will be reviewed in accordance with the standards published in 45 C.F.R S 164.524. (iv) You have the right to amend your Protected Health Information for as long as the Protected Health Information is maintained in the designated record set. We may deny your request for an amendment if the Protected Health Information was not created by us, or is not part of the designated record set, or would not be available for inspection as described under section 45 C.F.R. S 164.524, or if the Protected Health Information is already accurate and complete without regard to the amendment. (v) You have the right to request, and thereafter receive an accounting of the disclosures of your Protected Health Information for six years before the date on which you request the accounting. Exceptions to this accounting are those disclosures not allowed by law pursuant to section 164.528. Each request for an accounting will be reviewed pursuant to the rules of section 164.528. (vi) You also have a right to receive a copy of this Notice upon request.

The effective date of this Notice is January 1, 2014

I acknowledge receipt of Manhattan Pain Medicine, PLLC Notice of Privacy Practices

Name: _____ Signature: _____ Date: _____

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PAIN MEDICINE

Consent to Telehealth

Telemedicine is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. Electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records.
- Medical images.
- Interactive audio, video, and/or data communications.
- Output data from medical devices and sound and video files.

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Potential Benefits:

Improved access to medical care

Potential Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
2. The consulting physician(s) are not able to provide medical treatment to the patient through the use of telemedicine equipment nor provide for or arrange for any emergency care that I may require.
3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. Security protocols could fail, causing a breach of privacy of personal medical information.
5. A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical judgment errors.

Cost:

We will make every attempt to bill insurance for telehealth services provided, but many carriers do not reimburse for telehealth visits. If your insurance does not cover this service, the fees are as per our online self pay fee schedule.

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By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telemedicine. No information obtained during a telemedicine encounter which identifies me will be disclosed to researchers or other entities without my consent.

2. I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3. I have the right to inspect all information obtained and recorded during the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time. My physician has explained the alternative care methods to my satisfaction.
5. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out-of-state.
6. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse.
7. I will pay the above stated fees if not covered by my insurance, and consent to charging it to my credit card on file.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care by providers at Manhattan Pain Medicine, PLLC, Manhattan Pain Medicine Doctor, PLLC, Manhattan Pain Medicine Provider, PLLC, and Manhattan Pain Medicine Rehabilitation, PLLC to use telemedicine in the course of my diagnosis and treatment.

Patient Name: _____

Signature: _____ Date: _____

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Credit Card Authorization Form

Due to the out-of-pocket expense as outlined by your insurance plan, we require that you leave a credit card on file to be charged for services rendered.

Unexcused no-shows, tardiness of more than 20 minutes, and cancellation within 24 hours will be charged at $150 per incident.

This authorization will remain in effect until canceled. You may cancel this authorization at any time after the services rendered are paid for. The information supplied below will be considered private and confidential and is protected under the Health Insurance Portability and Accountability Act.

Cardholder Name: _____

Number: _____

Expiration: _____ / _____ Security Code: _____

Billing Zip Code: _____

I, _____, authorize Manhattan Pain Medicine to charge the credit card above for agreed upon services rendered, for which I have been given a Good Faith Estimate or a copy of the Self Pay Fee Schedule. I understand that my information will be saved to file for future transactions on my account.

Signature: _____ Date: _____

A photocopy of this consent shall be as effective and valid as the original.

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Self-Pay Fee Schedule 2026

Telemedicine		
Initial Consultation (45 min)	$1250(MD)	$600(PA)
Follow up (20 min)	$450(MD)	$250(PA)
Office		
Dr. Siefferman Initial Intake (PA) + Consultation (MD)	$1800	
Dr. Nino Initial Intake (PA) + Consultation (MD)	$1800	
Dr. Luis Auranguren Initial Consultation	$850	
Initial Consultation (60 min)	$1250(MD)	$600(PA)
Follow-up (30 min)	$450(MD)	$250(PA)
Procedure Visit (30 min)	$750(MD)	$450(PA)
Additional time (per 15 min)	$250	
Additional Procedure, each	$450	
IV Medication treatment	$500	
PRP	$1500	
Bone Marrow Aspirate Concentrate (BMAC)	$4800	
Viscosupplementation, per syringe	$100	
Feldenkrais (1 hour)	$250	
Pain Psychology (1 hour)	$300	
Surgical Center		
Procedure (not including facility or anesthesia fees)	$750+	
No-Show		
Non-emergent cancellation within 24 hours, 20+ minutes late to appointment, or no-show	$150	

Overbook

If an urgent appointment is requested by the patient and no openings are available, depending on the circumstances, the office day may be extended to accommodate this visit, and an overbook fee of $100 will be offered to the patient.

I have read, understand, and agree to pay the above fees for services rendered which may be either not covered or incompletely covered by insurance.

Signed: _____ Date _____

A Credit Card and deposit of $150 is required to reserve a self-pay appointment.