NAME	Gender	D.O.B.	D.O.A.	Phone#	Address	Insurance- Policy #	Claim #	Adjuster	Attorney
HONG, Kidong	Male	2/25/1964	1/25/2020	347-881-6848	42-09 163rd Street #3F Flushing, NY 11358	Geico	:0454864960101047	Frank Soto	Gabriel Law Firm T:800-554-5406 F:(516) 717-3349

smart care

Anjani Sinha Medcial PC

WC / NE / LIEN FORM

Patient Name: Hong, Kidong Date of Visit: 02/21/20

DOB: 02/25/64 (M) / F DOA: 01/25/20

Age: 56 Height: 5'9" Weight: 260

(Smoker): 1 pakage a day Non-Smoker: Occupation: home daycare

Type of Injury: X Auto Accident ___Work-Accident Other:

X Belted Driver ___ Passenger ___Pedestrian

Hospital: (Yes) / No Hospital name: Flushing Hospital

Past Medical History: Diabetes, (HBP,) Asthma, Cardiac disease, (None) _____

Past Surgical History: None (R) knee arthroscopy 4yrs accident.

Current Medications: None Anti hypertensive.

Allergies to Medications: Yes / (No) _____

Doing PT/Chiro: 4 weeks/months

Body parts Injured: (LSh) (R Sh) R Knee L Knee _____

PRESENT COMPLAINTS:

Pain both shoulders, (R) shld is worse than Left. P.T. is not helping him much.

PHYSICAL EXAMINATION:

R Shoulder: swelling / tenderness to palpation on the Superior aspect

Positive for Hawkins + O'Brien's Drop sign impingement sign, ++

ROM: Abduction 90 forward flexion 90 int. rotation 10 ext. rotation 15

V He has no motor or sensory deficit of the right upper extremity.

MRI (+) Fr Tear.

L Shoulder: swelling / tenderness to palpation on the Anti hyp. aspect

Positive for Hawkins O'Brien's Drop sign impingement sign,

ROM: Abduction 100 forward flexion 100 int. rotation ___ ext. rotation ___

V He has no motor or sensory deficit of the left upper extremity.

MRI

Anjani Sinha Medcial PC

R Knee: swelling / tenderness to palpation on the _____
Positive for McMurray, Lachman, Patellofemoral grinding test Anterior drawer
ROM: flexion ____ __ Knee is stable with varus and valgus stress test.
__He has no motor or sensory deficit of the right lower extremity.

L Knee: swelling / tenderness to palpation on the _____
Positive for McMurray, Lachman, Patellofemoral grinding test Anterior drawer
ROM: flexion ____ __ Knee is stable with varus and valgus stress test.
__He has no motor or sensory deficit of the left lower extremity.

Dx:

R Sh	L Sh	R Kn	L Kn
Tr rotator cuff tear	Tr rotator cuff tear	Tr medial tear	Tr medial tear
Tr labral tear	Tr labral tear	Tr lateral tear	Tr lateral tear
Tr SLAP tear	Tr SLAP tear	Tr medial & lateral tear	Tr medial & lateral tear
Tr impingment	Tr impingment	Tr ACL tear	Tr ACL tear
Tr torn _____	__Tr torn _____	Tr strain MCL	Tr strain MCL
Tr bursitis	__Tr bursitis	Tr torn _____	Tr torn _____
Tr tendinitis	__Tr tendinitis	Tr joint effusion	Tr joint effusion

Sx: R Sh L Sh R Knee L knee

Date scheduled:

MC required: Yes / No

Advised continued P.T.
Surg 4 weeks.

JS
2

ANJANI SINHA MEDICAL P.C.

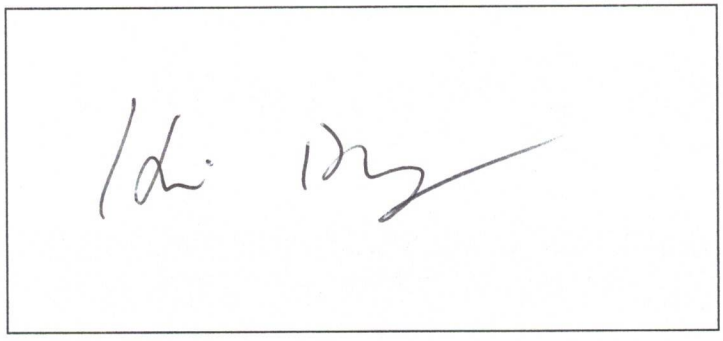
Orthopedic Surgery
164-10 Northern Boulevard, Suite 204,
Flushing, NY11358
Tel: 718-886-2011 **Fax:** 929-333-7950
anjanisinhamedicalpc@gmail.com

NF Forms

Date: 02/21/20

I, Hang, Kidong, hereby authorize **Anjani Sinha Medical PC** to use my signature as signed below for the following documents:

1. NY Motor Vehicle No-Fault AOB Form
2. NYS Form NF-2
3. NYS Form NF-3
4. Disclosure of Physician Ownership
5. Fee Guarantee Agreement
6. Letter to Attorney (LIEN Form)
7. HIPAA (OCA official Form N0.: 960)



NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: 0454864960101047

I, Kidong Hong **, ("Assignor") hereby assign to** Anjani Sinha Medical PC **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

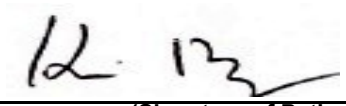
The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on 01/25/2020 **, not withstanding any other agreement**
(Print accident date)

to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

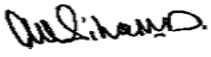
Kidong Hong
(Print name of Patient)


(Signature of Patient)

02/21/2020
(Date of signature)

42-09 163rd Street #3F ,Flushing ,NY ,11358
(Address of Patient)

Anjani Sinha Medical PC
(Print name of Provider)


(Signature of Provider)

164-10 Northern Blvd., Suite 204

Flushing, NY 11358
(Address of Provider)

02/21/2020
(Date of signature)

NYS FORM NF-AOB (Rev 1/2004)

ANJANI SINHA MEDICAL P.C.

Anjani Sinha, MD

Orthopedic Surgeon

94-11 Jamaica Avenue, Woodhaven, NY 11421

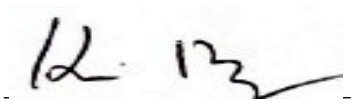
Tel: 917-300-5003 Fax: 929-333-7950

anjanisinhamedicalpc@gmail.com

DISCLOSURE OF PHYSICIAN OWNERSHIP

This notice is provided to you pursuant to the New York Public Health Law § 238-d. Practitioner disclosure requirements, and any other state and/or federal laws and regulations which may apply. New York state passed a law due to concerns that there may be a conflict of interest where a health practitioner makes a referral to a health care provider for the furnishing of any health related items or services where such practitioner (or immediate family member of such practitioner) has a financial relationship with or a financial interest in the health care provider. With certain exceptions, such referrals may be prohibited. The financial relationship must be disclosed to the patient as a condition to the referral. The patient must also be advised of his/her her eight to utilize a specifically identified alternative health care provider IF any such alternative is reasonably available.

I acknowledge that I have been placed on specific notice that **Dr. Anjani Sinha** has no financial and ownership in the **Surgery Center**. I have been informed that I have a right to be treated at a different facility of my own choosing if I so desire. After being fully informed of the above rights, my own volition, I expressly elect to have the procedure performed at the above-listed center. Any questions I may have had regarding this notice have been fully answered.

Kidong Hong		02/21/2020
PRINTED PATIENT NAME	PATIENT SIGNATURE	DATE

ANJANI SINHA MEDICAL P.C.

Anjani Sinha, MD

Orthopedic Surgeon

94-11 Jamaica Avenue, Woodhaven, NY 11421

Tel: 917-300-5003 Fax: 929-333-7950

anjanisinhamedicalpc@gmail.com

To ATTORNEY(S): _____

PATIENT NAME: Kidong Hong _____

DATE OF BIRTH: 02/25/1964 _____

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE AND DIRECT YOU, MY INSURANCE, AND/OR MY ATTORNEY TO PAY. DIRECTLY TO **ANJANI. SINHA, MEDICAL P.C.** THE SUMS AS MAYBE DUE AND OWING THIS OFFICE FOR SERVICES RENDERED ME BOTH BY REASON OF THIS ACCIDENT OR COMPENSATION BENEFITS, PERSONAL INJURY, NO-FAULT OR ANY OTHER INSURANCE BENEFITS OBLIGATED TO REIBMURSE ME OR FROM ANY SETTLEMENT, JUDGEMENT OR VERDICTION ON MY BEHALF AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID OFFICE. I HEREBY FURTHER GIVE LIEN TO SAID OFFICE AGAINST ANY AND ALL INSURANCE BENEFITS NAMED HEREIN, AND ANY PROCEEDS OF ANY SETTLEMENT, JUDGEMENT OR VERDICT WHICH MADE BE PAID TO ME AS A RESULT OF THE INJURIES OR ILLNESS FOR WHICH I HAVE BEEN TREATED BY SAID OFFICE THIS IS TO ACT AS ASSIGNMENT OF MY RIGHTS AND BENEFITSTO THE EXTENT OF THE OFFICES'S SERVICES PROVIDED. IN THE EVENT MY INSURANCE COMPANY AND AUTHORIZE THIS OFFICE'S NAME AND FURTHER, I AUTHORIZE THIS OFFICE TO COMPROMISE, SETTLE, OR OTHERWISE RESOLVE SAID CLAIMS OR CAUSE OF ACTION AS THEY SEE FIT.

I UNDERSTAND THAT I REMAIN PERSONALLY RESPONSIBLE FOR THE TOTAL AMOUNTS DUE TO THE FACILITY FOR THEIR SERVICES, I FURTHER UNDERSTAND AND AGREE THAT THIS ASSIGNMENT, LIEN AND AUTHORIZATION DOES NOT CONSTITUTE AND CONDERATION FOR THE FACILITY TO AWATE PAYMENT AND THEY MAY DEMAND PAYMENTS FROM ME IMMEDIATELY UPON RENDERING SERVICES AT THEIR OPTION. I AUTHORIZE THE FACILITY TO RELEASE ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY TO ENDORSE/SIGN MY NAME ON ALL CHECKS FOR PAYMENT OF MY MEDICAL BILL.

I FURTHER UNDERSTAND AND AGREE THAT THIS OFFICE MUST TAKE ANY ACTION TO COLLECT AN OUTSTANDING BALANCE ON MY ACCOUNT, I WILL BE RESPONSIBLE FOR PAYMENT OF AND WILL REIMBURSE THIS OFFICE FOR ALL COSTS OF SUCH COLLECTION EFFORTS, INCLUDING BUT NOT LIMITED TO ALL COURT COSTS AND ALL ATTORNEY FEES.

PATIENT Kidong Hong _____ DATE 02/21/2020 _____

WITNESS: _____

ATTORNEY SIGNATURE OR STAMP: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Kidong Hong	02/25/1964	
Patient Address		
42-09 163rd Street #3F ,Flushing ,NY ,11358		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

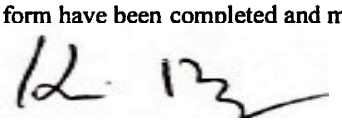
to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
❑ At request of individual ❑ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form



Signature of patient or representative authorized by law.

Date: 02/21/2020

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**