Welcome

Thank you for entrusting your care in our hands. We are a team of highly trained medical specialists and we take very seriously our responsibility to provide you with the highest quality medical care possible. We will be very professional, open and honest in every aspect of your care. We insist on a professional atmosphere and demeanor in the office because we owe it to you, the patient.

Copays and payments are due at the time of services. We accept check, cash, Master Card, Visa and Discover. There are no payments due for the first three post-operative visits, except for supplies and x-rays.

Please do not discuss fees with the physician. The doctor will focus only on your medical needs; the office staff will answer the financial questions.

(REVIEW THE ATTACHED HIPAA BROCHURE)

HIPAA Acknowledgement

I have been presented with a copy of the ***Centers Notice of Privacy Policies***, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my personal medical information.

____

____

____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed____ Date________________________________

If not signed by the patient, please indicate relationship to patient (e.g. spouse)

Relationship_________________________________

If the patient refuses to sign, indicate your attempt to obtain signature below

( ) Patient refused to sign this Acknowledgement

Date_________________ Time______________

Employee Name_______________________________

PHOENIX
HAND SURGERY

INSURANCE ACKNOWLEDGMENT & ENDORSEMENTS

PATIENT LEGAL NAME_____________________________________ DOB_______________________

RECORDS RELEASE

I hereby authorize ***Phoenix Hand Surgery*** to furnish any medical records and/or other necessary information needed to process an insurance claim.

________________________ ________________________ ________________

Signature of Responsible Party **Printed Name** **Date**

RX HISTORY CONSENT

I hereby authorize ***Phoenix Hand Surgery*** to pull my medication history from Sure Scripts to ensure an accurate account of my medications and dosage amounts.

________________________ ________________________ ________________

Signature of Responsible Party **Printed Name** **Date**

ASSIGNMENT OF BENEFITS

I, the undersigned, am the financially responsible party for the patient named above and agree to pay, in full, ***Phoenix Hand Surgery***, for all services rendered. I accept the Hand Center's fees as reasonable and customary.

In order to process an insurance claim, there must be complete patient and insurance information on file.

I irrevocably assign to Phoenix Hand Surgery and/or its physicians all payments from insurance company(ies) for medical services rendered and accept responsibility for paying any balance owed after the insurance has paid.

All patients whose insurance providers pay the patient directly, rather than the physician, herby agree to assign all benefits proceeds the patient receives from the insurance company to the physician's office. I agree to immediately endorse all checks received from my insurance company and to mail or bring them into the physician's office along with the Explanation of Benefits.

________________________ ________________________ ________________

Signature of Responsible Party **Printed Name** **Date**

PHOENIX
HAND SURGERY

AUTHORIZATION TO PHOTOGRAPH

I authorize the physician(s) and/or staff of the Phoenix Hand Surgery to take photographs prior to, during and/or following surgical treatment and use them for purposes of medical education, treatment planning, documentation or other purposes not limited to but including publication in journals.

______________________________ ______________________________ ____________________

Signature of Responsible Party **Printed Name** **Date**

AUTHORIZATION TO FORWARD MEDICAL RECORDS TO PRIMARY CARE PHYSICIAN ON FILE

I authorize ***Phoenix Hand Surgery*** to keep my primary care physician apprised of my treatment by forwarding my records to my physician on file as well as any other physicians I designate. This is to include all progress notes, diagnostic testing, operative reports and any other information that ***Phoenix Hand Surgery*** deems appropriate. This agreement is to continue for the duration of my treatment with ***Phoenix Hand Surgery*** unless written notification to cease correspondence is received. Additionally I understand that if I have a change in my primary care physician it is my responsibility to notify ***Phoenix Hand Surgery*** of this change and provide them the updated information.

______________________________ ______________________________ ____________________

Signature of Responsible Party **Printed Name** **Date**

NON-WORKMAN'S COMP DECLARATION

PLEASE READ- THE PHYSICIAN IS UNABLE TO DETERMINE WHETHER OR NOT THE SYMPTOMS YOU ARE SUFFERING ARE WORK RELATED.

By signing below you declare that you do not have a compensable work injury covered under a workman's comp claim at this time. It is your responsibility as the patient to notify our office if you file a work comp claim. You also understand that should your workman's comp claim be denied, you will responsible for all balances in full. If group health insurance is available, we must receive a copy for processing as soon as you are aware the claim has been denied. This is not a guarantee that we accept your group insurance.

______________________________ ______________________________ ____________________

Signature of Responsible Party **Printed Name** **Date**

DISABILITY/FMLA PAPERWORK

I the undersigned acknowledge that ***Phoenix Hand Surgery*** has a policy for all disability/FMLA forms, which requires a payment of $35 prior to the completion of the paperwork. This fee is assessed each time that a new form requires completion. Additionally staff must be given ample time to get the paperwork completed to ensure its accuracy, we ask that you give us at least 5 business days prior to the due date, as these forms can be extremely time consuming and must be completed while staff is not in clinic tending to patients.

______________________________ ______________________________ ____________________

Signature of Responsible Party **Printed Name** **Date**

PATIENT INFORMATION

Patient Name ____ ( ) male ( ) female
PRINT YOUR LEGAL NAME ONLY

Date of Birth ____________________ **Age** _________ **Social Security Number**____________________________

Home #__________________________ **Work #**__________________________ **Alt #**_______________________

Address ____ **Apt #**____________

City_________________________________ **State** __________________ **Zip**______________

Driver's License #______________________ **State**___________________

E-Mail Address____

Employer's Name ____ **Occupation**___________________________

Employer's Address____ ________**City**_________________________

State ____________________ **Zip**______________ **Employer's Phone#**__________________________________

Spouse's Name ____ **Tel #** ________________________________

Person to notify in case of emergency____________________________________**Relationship**____________________

Tel # _________________________________ **Alternate #** ________________________________

Primary Care Physician _________________________________ **Phone number** ______________________________

Cardiologist ____ **Phone number** ______________________________

FINANCIAL INFORMATION

( ) Self Pay ( ) Insurance ( ) Medicare ( ) Worker Comp Claim ( ) Other

Primary Insurance Co____ **Tel #** ______________________________

Insurance ID# ____ **Group #** ______________________________

Insured's Name _______________________**Insured's DOB** ___________ **Insured's Social**________________________

Relationship to patient _________________________ **Insured's Employer Name** _____________________________

Secondary Insurance Co_______________________________________ **Tel #** ______________________________

Insurance ID# ____ **Group #** ______________________________

Insured's Name _______________________**Insured's DOB** ___________ **Insured's Social**________________________

Relationship to patient _________________________ **Insured's Employer Name** _____________________________

Patient Signature_______________________________________ **Date**_________________________________

How did you get referred to this office, please provide as much information as possible:

Phoenix Hand Surgery Website:__________

Google Search: ____

Physician Name: ____________________________________ Phone:_____________________________

Patient Referral: ____

Urgent Care: _________ Name/Location:____

Hospital: ____

Other- Please List: ____

Preferred Pharmacy Information

Pharmacy Name: ________________________________ Phone#:__________________________ Fax:________________________

Address:____ City/State/Zip:__________________________________

Second Pharmacy:

Pharmacy Name: ________________________________ Phone#:__________________________ Fax:________________________

Address:____ City/State/Zip:__________________________________

Patient Name:______________________________________

REASON FOR TODAY'S VISIT:____

HISTORY:

Are you (Circle One) Right Handed Left Handed Ambidextrous

What type of work do you do? _______________________________ Retired_______

If Disabled Why?____

Did your hand problem result from a specific injury? Yes _____ No______

Was the injury due to a: Work Injury ______ Car Accident _______

Injury/Accident Date: ___________________

Describe the nature of the injury: ____

Is/was there a lawyer involved in your injury? Yes______ No______

How long have you had the condition? ___________________________

Do you have any neck pain?______________________

Do you see anyone for this? ______________________________________

Do you have symptoms in your legs? ______________

Do you see anyone for this? ______________________________________

Please **rate** your pain on a scale of 0-10 (10 being the most painful): __________

Is the **pain**, please check all that apply:

□ Constant □ Intermittent □ Occasional □ Sharp □ Aching □ Stabbing

□ Throbbing □ Burning □ Electrical □ Shooting □ Spasmodic □ Dull

What **symptoms** are you experiencing?

□ Numbness □ Tingling □ Locking □ Popping □ Catching □ Giving Way □ Swelling

□ Grinding □ Stiffness □ Weakness □ Night pain/wakening □ Pain with lifting

What, if anything, makes your symptoms **better**?

____

What, if anything, makes your symptoms **worse**?

____

Are you: □ Improving □ Getting Worse □ Staying the same

Have you seen another physician for this problem/injury? □ Yes □ No

If yes, who? ____

What **treatments** have you tried? □ Physical Therapy □ Splint □ Steroid Injection □ Acupuncture □ Chiropractic manipulation

□ Other:____

□ Pain Medications: ___________________________________

Where are your symptoms **located**:

Right: □ Thumb □ Index Finger □ Middle Finger □ Ring Finger □ Small Finger □ Palm □ Wrist □ Forearm □ Elbow

□ Other:___________________________

Left: □ Thumb □ Index Finger □ Middle Finger □ Ring Finger □ Small Finger □ Palm □ Wrist □ Forearm □ Elbow

□ Other:___________________________

IMAGING STUDIES

Test	Date (month/year)	Where were the tests done?
□ X Rays	________________	______________________________
□ MRI Scan	________________	______________________________
□ CT Scan	________________	______________________________
□ EMG/NCS	________________	______________________________
□ Other	________________	______________________________

MEDICATIONS

Please list all medications you are currently taking. Include vitamins, diet pills and over the counter:

Medication:	Dosage:	Frequency
__________________________________	________________	___________________
__________________________________	________________	___________________
__________________________________	________________	___________________
__________________________________	________________	___________________

Medical History

Please check current or previous medical conditions:

□ Anemia	□ Irregular Heartbeat	□ Arthritis	□ Chemical Dependency	□ HIV
□ Heart Attack	□ Rheumatoid Arthritis	□ Blood Clots	□ High Blood Pressure	□ Thyroid
□ Alcoholism	□ High Cholesterol	□ Liver Disease	□ Depression	□ Diabetes
□ Heart Disease	□ Stroke/Seizures	□ Cancer	□ COPD	□ Poor Circulation
□ Asthma	□ Pulmonary Embolus	□ Osteoporosis	□ Hepatitis B or C	

□ Other: ____

Have you ever had a blood transfusion? □ No □ Yes If yes, when? ____

Do you have any bleeding problems? □ No □ Yes If yes, please list:____

DRUG ALLERGIES

Do you have any drug allergies □ No known drug allergies □ YES

If yes please list drug allergies:____

List all other allergies: ____

ALLERGIES TO LATEX □ NO □ YES OR ADHESIVES □ NO □ YES

ANESTHESIA – Have you or any close family member(s) had any problems with anesthesia? □ NO □ YES – PLEASE LIST
____
____

SURGICAL HISTORY

Please list all previous surgeries, include the year performed:____
____
____
____

Hospitalizations

□ Denies Hospitalization or List all hospitalizations, including reason and dates: ______________________________________
____
____

FAMILY HISTORY

Please check family history conditions:

Father	□ Diabetes	□ Hypertension	□ Heart Disease	□ Mental Illness	□ Cancer	□ Other:____________________________
Mother	□ Diabetes	□ Hypertension	□ Heart Disease	□ Mental Illness	□ Cancer	□ Other:____________________________
Grandfather	□ Diabetes	□ Hypertension	□ Heart Disease	□ Mental Illness	□ Cancer	□ Other:____________________________
Grandmother	□ Diabetes	□ Hypertension	□ Heart Disease	□ Mental Illness	□ Cancer	□ Other:____________________________
Siblings	□ Diabetes	□ Hypertension	□ Heart Disease	□ Mental Illness	□ Cancer	□ Other:____________________________
Children	□ Diabetes	□ Hypertension	□ Heart Disease	□ Mental Illness	□ Cancer	□ Other:____________________________

SOCIAL HISTORY

Current Smoker □ NO □ YES – How many per day? _________ How many years? __________
Former Smoker □ NO □ YES- How long has it been since you last smoked? _______________
Drink Alcohol □ NO □ YES – How many per day? ___________ □ Socially
Street Drugs □ NO □ YES- Frequency: __________________________________
Marital Status: □ Married □ Single □ Widowed □ Divorced

REVIEW OF SYSTEMS

Check if you have current symptoms or current known medical problems in the following areas.

General/Constitutional:

Change in Appetite	□	Yes	□	No
Chills	□	Yes	□	No
Fatigue	□	Yes	□	No
Fever	□	Yes	□	No
Lightheadedness	□	Yes	□	No
Night Sweats	□	Yes	□	No

Ophthalmologic:

Blurred Vision	□	Yes	□	No
Discharge	□	Yes	□	No
Dry Eye	□	Yes	□	No
Eye Pain	□	Yes	□	No
Eye Problems	□	Yes	□	No
Itching	□	Yes	□	No
Red Eye	□	Yes	□	No

ENT:

Hoarseness	□	Yes	□	No
Nasal Discharge	□	Yes	□	No
Loss of Hearing	□	Yes	□	No
Ear Pain	□	Yes	□	No
Nosebleed	□	Yes	□	No

Endocrinology:

Acne	□	Yes	□	No
Diabetes	□	Yes	□	No
Excessive Thirst	□	Yes	□	No
Hair Loss	□	Yes	□	No
Hot Flashes	□	Yes	□	No
Weakness	□	Yes	□	No

Respiratory:

Asthma	□	Yes	□	No
Cough	□	Yes	□	No
Shortness of Breath	□	Yes	□	No
Lung Disease	□	Yes	□	No
Wheezing	□	Yes	□	No

Cardiovascular:

Heart Attack	□	Yes	□	No
Chest Pain	□	Yes	□	No
Pacemaker	□	Yes	□	No
CHF	□	Yes	□	No
Angioplasty (Stent)	□	Yes	□	No
Irregular Heartbeat	□	Yes	□	No
Angina	□	Yes	□	No

Gastrointestinal:

Ulcer	□	Yes	□	No
Abdominal Pain	□	Yes	□	No
Blood in stool	□	Yes	□	No
Constipation	□	Yes	□	No
Diarrhea	□	Yes	□	No
Heartburn	□	Yes	□	No
Vomiting	□	Yes	□	No

Hematology:

Anemia	□	Yes	□	No
Bleeding Problems	□	Yes	□	No
Easy Bruising	□	Yes	□	No
Prolonged Bleeding	□	Yes	□	No

Genitourinary:

Pain while Urinating	□	Yes	□	No
Urethral Discharge	□	Yes	□	No
Pain in Pelvis	□	Yes	□	No

Musculoskeletal:

Arthritis □ Yes □ No
Back Problems □ Yes □ No
History of Gout □ Yes □ No
Joint Stiffness □ Yes □ No
Leg Cramps □ Yes □ No
Painful Joints □ Yes □ No
Swollen Joints □ Yes □ No

Skin:

Acne □ Yes □ No
Blistering of Skin □ Yes □ No
Discoloration □ Yes □ No
Eczema □ Yes □ No
Excessive Sun Exposure □ Yes □ No
Keloid Formation □ Yes □ No

Neurologic:

Balance Difficulty □ Yes □ No
Difficulty Speaking □ Yes □ No
Dizziness □ Yes □ No
Fainting □ Yes □ No
Gait Abnormality □ Yes □ No
Irritability □ Yes □ No
Stroke □ Yes □ No

Psychiatric:

Auditory/Visual Hallucinations □ Yes □ No
Delusions □ Yes □ No
Mental or Physical Abuse □ Yes □ No
Nervous Breakdown □ Yes □ No
Psychiatric Condition □ Yes □ No
Suicidal Thoughts □ Yes □ No