Hand and Microsurgery Associates

Hand and Arm Therapy Specialists

**All fields must be completed to be seen by the physician**

Patient Name_____ Account# _____

Patient Address_____

City_____ State _____ Zip_____

Email_____

Home Phone_____ Cell Phone_____

Marital Status S ☐ M ☐ D ☐ W ☐ Sex M ☐ F ☐ DOB_____ Age____ SSN# _ _ _ - _ _ - _ _ _ _

Are You Employed? Yes ☐ No ☐ Disabled ☐ Retired ☐ Are You A Student? Yes ☐ No ☐

Employer Name_____ Work Phone _____

Emergency Contact_____ Relationship_____

Emergency Contact Phone Number_____ Home ☐ Cell ☐ Work ☐

Family Doctor _____Address/Phone: _____

Referring Doctor_____ Address/Phone: _____

If No Referring Doctor, How Did You Hear About Us?

Internet ☐ Emergency Room ☐ Urgent Care ☐ Existing Patient ☐ Insurance ☐ Friend/Family ☐

If Patient Is Under 18, Which Parent or Legal Guardian Brought The Patient? _____

Relationship: Mother ☐ Father ☐ Other ☐

Address_____

DOB_____ SSN_ _ _ - _ _ - _ _ _ _

Primary Insurance:

Insured Relationship to Patient: Self ☐ Spouse ☐ Mother ☐ Father ☐ Other ☐

Insurance Company_____

Name of Insured_____

DOB of Insured_____ SS# of Insured _ _ _ - _ _ - _ _ _ _

Secondary Insurance (If Applicable):

Insured Relationship to Patient: Self ☐ Spouse ☐ Mother ☐ Father ☐ Other ☐

Name of Insured_____

DOB of Insured_____ SS# of Insured _ _ _ - _ _ - _ _ _ _

I understand and request that payment of authorized insurance company benefits be made directly to Hand and Microsurgery Associates on my behalf for all rendered services. I authorize any holder of medical information about me to release information needed to determine these benefits or the benefits payable to related services. I am responsible for any co-pay, co-insurance, deductible and non-covered amounts. I authorized my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and /or mailing address provided.

**Signature_____Date_____

Patient Reviewed_____ Date_____ Patient Reviewed _____ Date_____

Patient Reviewed _____ Date _____ Patient Reviewed _____ Date _____

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**HIPAA Confidentiality & Contact Information**

I understand that HMA-HATS is legally permitted to use and disclose my protected health information ("PHI") for the purposes of treatment, payment, and health care operations without my consent. You have the legal right to a copy of our current HIPAA Privacy Notice at any time.

_____☐_____ I have requested and received a copy of the HIPAA Privacy Notice today.

_____☐_____ I do not want a copy the HIPAA Privacy Notice today.

**May we leave a message with other residents in your home?** **Y** ☐ **N** ☐
**May we leave a message on your answering machine or voice mail?** **Y** ☐ **N** ☐
**May we contact you at work?** **Y** ☐ **N** ☐ **NA** ☐
**In the event that we schedule surgery for you, may we leave a message regarding your surgery date?** **Y** ☐ **N** ☐

I give my permission to HATS/HMA to discuss or release my medical information to the following:

| NAME | RELATIONSHIP | PHONE |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Wireless Telephone Communication**
I understand that if I provide a wireless telephone number I may be contacted by text, artificial or pre-recorded messages, automatic dialing services or email for communication regarding billing and payment for services.

By my signature below, I confirm that I have read and understand the above policies and give my consent.

_____ Date _____
Signature of patient (or responsible party, if a minor)

---

Printed name

Patient Reviewed _____ Date _____
Patient Reviewed _____ Date _____
Patient Reviewed _____ Date _____
Patient Reviewed _____ Date _____

**Consent to Treat**

I, the undersigned, agree and give my consent for my physicians or their assistants to provide services deemed necessary to diagnose and treat my condition. This care may include, but is not limited to, diagnostic radiology and laboratory procedures, administration of drugs, and physical therapy.

**Patient Financial Responsibility**

Fees are standardized and are based on the complexity of your visit or procedure. Payment of copayments and any outstanding balance(s) is required at the time of service. We accept cash, personal checks, Visa, MasterCard and Discover. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service(s) are rendered. In order for us to file a claim, you must present a current copy of your insurance card at each visit and communicate any changes in your personal contact information.

Most insurance policies specify that some of the cost of the patient's care is the patient's responsibility. This can be accomplished through any combination of co-payments, co-insurance or deductibles. Co-payments are due when you check in for your appointment. Co-insurance and deductible are determined by your insurance company and reported to us on your explanation of benefits (EOB). Once we are notified, we will send you a statement. This charge is payable upon receipt of the statement. Once payments are received, they will be automatically applied to the oldest outstanding balance on your account. If you would like a payment to be applied to a specific charge, please notify your staff at the time of payment.

It is not the policy of Hand and Microsurgery Associates to hold your account for settlement of a legal suit. In the case of an open claim through an auto or homeowners insurance, you are responsible for the specific charges.

Federal state laws and insurance company contracts prevent Hand and Microsurgery Associates from adjusting off co-pays, deductible and any other patient responsible balance after insurance has paid.

**Insurance Plans**

Your insurance coverage is a contact between you, your employers and the insurance company; we are not a party to that contact. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify the physician and the facility you are scheduled at participates with your plan and that the service(s) that you intend to receive are covered. In addition, because some insurance plans require either pre-certification and/or a referral from a primary care provider before you can be seen, please ask if these are required and obtain them if necessary. Not all services are a covered benefit in all plans so it is very important that you understand the provisions of your individual policy. Some insurance companies select certain services that they will not cover; so we cannot guarantee payment of all claims by your insurance company. If your insurance company pays only a portion of your claim or rejects your claim, they will notify you through an explanation of benefits (EOB). Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation for your charges.

We want to confirm you are aware of the various charges you will be responsible for should you have surgery or be referred for therapy.

Charges you will be responsible for may include any co-payments, deductibles and co-insurance due. In addition, if you have surgery you may also be responsible for the surgeon's fee and co-insurance and/or deductible for anesthesia and facility charges at The Hand Center.

**Making and Keeping Appointments**

If you need to cancel your appointment or cannot keep your appointment please call the office PRIOR to the appointment time. This allows us to accommodate other patients who need to be seen. No shows will result in a $35 charge that your insurance company will not pay. Initials _____

**Non-Payment of Outstanding Accounts**

Accounts that are not paid in a reasonable amount of time may be sent to an external collections agency and reported to the credit bureaus. If this occurs, you may be required to pay the outstanding balance in full plus any application fees prior to coming back into the practice.

**Form Completion Policy**

Forms Charge- If your employer requires Family Medical Leave Act (FMLA) or Disability paperwork to be completed by your physician, the turnaround time is seven (7) business days and there is a $15 fee for this service, to be paid in advance.

Medical Records Charge- If you would like a copy of your medical records sent to yourself or another physician, these copies are billed at a per page basis, to be paid in advance, in accordance with HIPAA and Ohio state law. The per page fee schedule is available upon request. If a collaborating physician (primary care of specialist) requests portions of your chart to assist in your care there is no charge.

Returned Check Fee- Non Sufficient Funds (NSF) checks are subject to a $25 fee (in addition to fees from your bank).

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# AUTHORIZATIONS

I, the undersigned agree and authorized the providers of Hand and Microsurgery Associates to provide the following:

**Authorization to Provide Care**

I authorize the providers of Hand and Microsurgery Associates to provide any medical care deemed necessary according to their professional opinions.

**Authorization and Release of Information for Billing**

I authorize my insurance benefits to be paid directly to Hand and Microsurgery Associates. I authorize the release of any information by Hand and Microsurgery Associates to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account unless other arrangements have been made.

**Patient Certification, Authorization to Release Medical Information**

I, the undersigned authorize Hand and Microsurgery Associates to release any medical information that may be necessary to request claim reimbursement from the insurance carriers or other payers to whom claims have been or are being submitted.

**Billing Protocol**

If I am scheduled for surgery I may be responsible for co-insurance, deductibles and co-payment for anesthesia during surgery and charges by the surgical center as well as my physician. I am also responsible for any co-pays, deductibles and co-insurance for therapy and office visits with my doctor, as per my insurance policy.

**Credit Information and Collection Fees**

I, the undersigned agree that if payment on this patient's account is not made I will pay reasonable attorney's fees and 30% collection fees incurred for the collection process. I also authorize the release of credit information to the appropriate information gathering agencies.

**I have reviewed the Hand and Microsurgery Associates Financial Policy and Authorizations: Please initial_____**

**I certify that I have read the forgoing and I am the patient or am duly authorized to execute the above agreement for the patient and accept its terms**

**Responsible Party _____Relationship to patient Self ☐ Parent/Guardian ☐**

**Signature_____ Date _____**

**Printed Name _____**

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CHIEF COMPLAINT (Reason for visit today): _____

Date: _____ Date of Injury: _____

Account# _____ Duration of Symptoms: _____

Name: _____ Location of Injury: Left ☐ Right ☐

DOB: _____ Sex: _____ Dominant Hand: Left ☐ Right ☐

ALLERGIES:

| | | |
|---|---|---|
| Are you allergic to Latex? | Y ☐ | N ☐ |
| Are you allergic to metals? | Y ☐ | N ☐ |
| Drug Allergies? | Y (List) | N ☐ |

_____

_____

FAMILY HISTORY:

| | | |
|---|---|---|
| Diabetes | Y ☐ | N ☐ |
| Cancer | Y ☐ | N ☐ |
| Heart Disease | Y ☐ | N ☐ |
| Bleeding Disorders | Y ☐ | N ☐ |

Other: _____

**Are you currently experiencing any of the following?** (Please Mark Y/N)

| | | | | | |
|---|---|---|---|---|---|
| Fever | Y ☐ N ☐ | Numbness/Tingling | Y ☐ N ☐ | Joint Pain | Y ☐ N ☐ |
| Chills | Y ☐ N ☐ | Migraines | Y ☐ N ☐ | Abdominal Pain | Y ☐ N ☐ |
| Weight Loss | Y ☐ N ☐ | Weakness | Y ☐ N ☐ | Reflux | Y ☐ N ☐ |
| Irregular Heartbeat | Y ☐ N ☐ | Shortness of Breath | Y ☐ N ☐ | Difficulty Swallowing | Y ☐ N ☐ |
| Unusual Bruising | Y ☐ N ☐ | Joint Swelling | Y ☐ N ☐ | Excessive Bleeding | Y ☐ N ☐ |
| Rashes | Y ☐ N ☐ | | | | |

**PAST MEDICAL HISTORY** (Please Mark Y/N)

| | | | | | |
|---|---|---|---|---|---|
| MRSA | Y ☐ N ☐ | Cardiac Stents | Y ☐ N ☐ | Ulcers | Y ☐ N ☐ |
| Tuberculosis (TB) | Y ☐ N ☐ | Defibrillator | Y ☐ N ☐ | Thyroid Disease | Y ☐ N ☐ |
| Hepatitis | Y ☐ N ☐ | Murmur | Y ☐ N ☐ | Liver Disease | Y ☐ N ☐ |
| HIV | Y ☐ N ☐ | Stroke | Y ☐ N ☐ | Sleep Apnea | Y ☐ N ☐ |
| Vancomycin-Resistant Enterococci | Y ☐ N ☐ | Bleeding/Blood Thinners | Y ☐ N ☐ | Do you use a C-PAP? | Y ☐ N ☐ |
| | | Artificial Joint(s) | Y ☐ N ☐ | | |

**CURRENT MEDICAL PROBLEMS** (Please Check Y/N)

| | N | Yes, <1 year | Yes, >1 year | | N | Yes, <1 year | Yes, >1 year | | N | Yes, <1 year | Yes, >1 year |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | ☐ | Cancer | ☐ | ☐ | ☐ | Osteoporosis | ☐ | ☐ | ☐ |
| Heart Condition | ☐ | ☐ | ☐ | Circulation/Vascular Problems | ☐ | ☐ | ☐ | Chronic Pain/Fibromyalgia | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | Peripheral Neuropathy | ☐ | ☐ | ☐ | Psychological Condition | ☐ | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | ☐ | Double Vision | ☐ | ☐ | ☐ | Dizziness/Faintness | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | Night Sweats/Pain | ☐ | ☐ | ☐ | Head Injury | ☐ | ☐ | ☐ |
| Kidney Condition | ☐ | ☐ | ☐ | Sexual Dysfunction | ☐ | ☐ | ☐ | Obesity | ☐ | ☐ | ☐ |
| Blood Clot/DVT | ☐ | ☐ | ☐ | Groin Numbness | ☐ | ☐ | ☐ | Seizures | ☐ | ☐ | ☐ |
| Metal Implants/ Pacemaker | ☐ | ☐ | ☐ | Bladder/Bowel Problems | ☐ | ☐ | ☐ | Headaches | ☐ | ☐ | ☐ |
| | | | | | | | | Fractures | ☐ | ☐ | ☐ |

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Do you use tobacco? YES NO If so, what type and how much? _____

Do you drink alcohol? YES NO If so, how much and how frequently? _____

Do you have an Advance Directive, Medical Power of Attorney or Living Will? YES NO

If yes, please provide a copy for our office Date Document Received _____

Height_____ Weight_____

| Medications **INCLUDE** Over The Counter and Supplements | Dose | Previous Surgeries | Year |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

On a scale from 0 to 10, 0 being "no pain" and 10 being "worst pain imaginable", please rate:

Your pain at rest 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Your pain with activity 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Have you ever had an adverse reaction to anesthesia?

YES NO **Please explain** _____

Have you or a family member ever experienced high fever due to anesthesia (malignant hyperthermia)? YES ☐ NO ☐

Patient Signature _____ Date _____

Physician Signature _____ Date _____