The Bronstein HAND Center

website

Patient Registration Form

****** DID YOU BRING XRAYS? _____***

PATIENT NAME: _____ MALE____FEMALE_____
ADDRESS: _____APT #_____
CITY: _____STATE: _____ ZIP_____
DATE OF BIRTH: _____AGE: _____MARITAL STATUS _S M D_ SS# _____
HOME PHONE: _____CELL / ALTERNATIVE PHONE: _____
OCCUPATION: _____
EMPLOYER: _____WORK PHONE: _____
EMPLOYER ADDRESS: _____
PERSON TO NOTIFY IN CASE OF EMERGENCY (ICE) : _____
PHONE: _____ADDRESS: _____

REFERRED BY: _____(Doctor, Patient, Attorney, Insurance, Ad)
IF YOU WERE INJURED, DATE OF INJURY: _____PLACE: _____
HOW WERE YOU INJURED? _____
WHERE WERE YOU LAST TREATED FOR THIS PROBLEM: _____
BODY PART BEING TREATED: _____ ARE YOU RIGHT- OR LEFT-HANDED? ___

WORKERS COMP INSURANCE: _____PHONE #: _____
CLAIM #: _____CONTACT NAME (Claims Manager/Nurse Case Manager) _____

DO YOU HAVE AN ATTORNEY FOR YOUR INJURY? YES ( ) NO ( )
NAME OF ATTORNEY: _____PHONE: _____

DO YOU HAVE MEDICAL INSURANCE? YES ( ) NO ( )

*****If yes, please fill out the following even if this is a work-related injury*****

PRIMARY INSURANCE: _____
SUBSCRIBER: _____
RELATIONSHIP TO PATIENT: _____
INSURED DATE OF BIRTH: _____
GROUP #: _____
ID# _____
SS# _____
PHONE # OF INSURANCE: _____
INSURED EMPLOYER: _____
PHONE #: _____

SECONDARY INSURANCE: _____
SUBSCRIBER: _____
RELATIONSHIP TO PATIENT: _____
INSURED DATE OF BIRTH: _____
GROUP #: _____
ID# _____
SS# _____
PHONE # OF INSURANCE: _____
INSURED EMPLOYER: _____
PHONE #: _____

Please see next form for all financial information and authorizations. I hereby authorize and consent to medical treatment, testing, and procedures that my physician deems advisable and necessary based on his/her judgment.

_____ _____
Patient/Guardian signature Date

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HISTORY FORM

(Please Fill out Completely)

TODAY'S DATE: _____

NAME: _____PHONE # : _____ AGE: _____

WHICH HAND DO YOU WRITE WITH ? *RIGHT OR LEFT*

OCCUPATION: _____ EMPLOYER: _____

REFERRED BY: _____*(Doctor, Prior Patient, Family, Friend, Ad)*

AREA OF BODY YOU ARE BEING SEEN FOR? _____DATE OF INJURY OR DURATION:_____

DESCRIBE HOW YOUR PROBLEM STARTED: _____

Please Fill out ALL areas 1 through 10

1) PAST MEDICAL HISTORY: *: (PLEASE* ***CIRCLE*** *or write in)*

Carpal Tunnel (circled)	
Anxiety	*Heart Disease*
Arthritis	*Hypertension*
Asthma/COPD	*Kidney Disease*
Bursitis	*Neck Injury*
Cancer	*Osteoporosis*
Carpal Tunnel	*Rheumatoid Arthritis*
Cubital Tunnel	*Scleroderma*
Depression	*Sleep Apnea*
Diabetes	*Stroke*
Gastritis/Ulcer	*Thyroid Disease*
Glaucoma	*Tendinitis*
Heart Attack	*Recent Wt. Change (≥ 15#)*

_____ _____

2) FAMILY MEDICAL HISTORY *(Check* ***"√"*** *if positive)*

Family Member	*Diabetes*	*Heart Disease*	*High Blood Pressure*	*Thyroid Disease*	*Finger Deformities*
Mom					
Dad					
Sister					
Brother					

3) PAST SURGICAL HISTORY*: (PLEASE CIRCLE OR WRITE)*

Appendectomy	*Hernia Repair*
Angioplasty	*Heart Bypass*
Arthroscopy	*Hysterectomy and/or Tubal Ligation*
C-section	*Laparoscopy*
Carotid Surgery	*Oral Surgery*
Carpal tunnel release.	*Prostate Surgery*
Cosmetic	*Spine Surgery*
Cubital tunnel release.	*Tonsillectomy*
Fracture Care	*Trigger Finger Release*
Gall Bladder	*Wrist Surgery*

4) HISTORY OF ANESTHETIC PROBLEMS/COMPLICATIONS? *(i.e., nausea)*

5) CURRENT MEDICATIONS & DOSE *(i.e., Aspirin 81, Coumadin 7.5mg, Keflex 500 mg)*

*
*
*
*
*
*
*
*

6) ***PHARMACY NAME****, (Cross streets) (i.e.,* ***CVS Town Center & Charleston etc****.)*

*Preferred Pharmacy:*_____

7) DRUG ALLERGIES*? (i.e., Penicillin, Sulfas, Iodine)*

8) ***SOCIAL HISTORY:***

Tobacco: _____pk(s)/day

Alcohol: _____

Hobbies/Interests: (i.e., golf, knitting, filling out medical forms)

9) ***WORK STATUS:***

Full duty *Full-time*

Light duty *Part-time*

Retired

10) CURRENT WORK RESTRICTIONS _____

Is this a Work Comp Visit? Yes / No

Date_____

Name _____ Date of Birth _____

Phone Number(s) _H_____ Cell_____ Height: _____Wt: _____

Our updated software will allow for patient correspondence…..

Email address_____

Review of Systems

Please circle all items below that apply:

Constitutional *Unexpected wt. loss, weight gain, fever, chills, fatigue*

Eyes *Corrective lenses, blurred/double vision, eye pain, redness, watering*

ENT *Headache, difficulty swallowing, nose bleeds, ringing in ears, earaches*

Cardiovascular *Chest pain, palpitations, fainting, murmurs*

Respiratory *Short of breath, wheezing, cough, tightness, inspiration pain, snoring*

GI *Heartburn, nausea, vomiting, constipation, diarrhea, bloody/tarry stool*

Genitourinary *Frequency, urgency, difficult/painful urination, flank pain, bleeding*

Musculoskeletal *Joint pains, swelling, instability, stiffness, redness, heat, muscle pain*

Skin *Skin changes, poor healing, rash, itching, redness, Latex allergy*

Neurologic *Numbness/tingling, unsteady gait, dizziness, tremors, seizure*

Psychiatric *Nervousness, anxiety, depression, hallucinations,* HATING PAPERWORK

Hematologic *Easy bleeding, bruising, taking blood thinners*

Endocrine *Excessive thirst, Excessive urination, heat intolerable, cold intolerable*

Allergic *Reaction to foods or environment*

Please add any details to circled items that you desire below:

_____

_____

_____

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

All fees for medical care are based on the usual, reasonable, and customary fee charged in this area by physicians of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. ALL THE FORMS HAVE TO BE FILLED OUT IN THEIR ENTIRETY

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm you status. We will do all we can to assist you with your insurance claims; however, insurance is a contract between you and your insurance carrier and final responsibility for payment of your account rests with you. Our office will bill your insurance carrier for a 60 day period after which it will be your responsibility to pay your unpaid balance and we will furnish paperwork for you to pursue reimbursement from your carrier.

The exception to the above is for those patients with injuries that are work-related and are covered by Worker's Compensation. These patients are not responsible for their bills, unless their claim is denied. This is why we need information about your private primary insurance so that the billing process can go smoothly if Workman's compensation denies your claim.

Prior authorizations obtained for procedures and therapy by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions and your insurance carrier determines final payment. A deposit is required if you are being scheduled for surgery. If an assistant is required at the time of surgery to improve the quality of your surgical outcome, the assistant's fee is in addition to the surgeon's fee. Furthermore, you will receive and will be obligated to satisfy bills from surgical centers, hospitals, and anesthesiologists for surgical procedures independent of our office's billing.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medigap, Veteran's administration, or other designated payer of medical benefits to my doctor for clinical, surgical and/or therapy services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. 20% interest to be accrued on unpaid balances monthly. *Minimum monthly payments of $ 20.00 are required on account balances less that $100. On accounts of $100 or more, a minimum of 20% of the outstanding balance is required each month until the account is paid*. A 30% collection fee will be added to unpaid balances that are sent to a collection agency. A photocopy of the assignment is considered as valid as the original. There will be a $35.00 fee for all return check items.

I also authorize my doctor to release to my insurance carrier, Medicare, Medigap, Veteran's administration, or other designated payer of medical benefits any medical information about me needed to determine these benefits or the benefits payable for service.

I hereby consent to and authorize medical treatment, tests, procedures and/or therapy performed in the office that my physician deems advisable and necessary based on his judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

_____ _____

Patient or Responsible Party's signature Date

Printed Name of the above signature 2/10

No Show Policy

(Missing appointments or scheduled surgeries)

Unfortunately we have found it necessary to charge for missed appointments. Patients that do not show up for their scheduled appointments are preventing us from scheduling other patients with urgent needs.

As a courtesy, we will confirm your appointment prior to its scheduled date, however the final responsibility rests with the patient. Effective March 1, 2012, there will be a charge of $50 for each missed appointment.

A missed appointment is defined as:

- Not showing to a scheduled appointment
- Cancellation or rescheduling without 48 hours notice
- Two (2) "no shows" constitute dismissal

A missed surgery appointment without prior notice may lead to unnecessary delay in care caused by the patient and can impact outcome. It will be at the discretion of the surgeon whether or not the delay merits dismissal from our practice. We will provide information regarding other surgeons to pursue completion of care upon request, however, it will be the responsibility of the patient to contact and transfer their care to the suitable surgeon. We will not assume responsibility for the patient's self-imposed (by missed scheduled appointments) delay in care.

You must cancel by direct phone call or email your cancellation to reception@bronsteinhandcenter.com

Patient/Guardian signature: _____Date:

Please read the following policies regarding your co-pays and insurance paperwork

Co-Pays

1. Co-pays are expected prior to your appointment.
    a. Co-payment is due when you **check-in** for your appointment. We reserve the right to reschedule your appointment if you do not fulfill YOUR insurance company's requirement of co-payment at the time of visit.
2. Co-payments incurred during your visit will be collected at checkout. These may include x-ray, durable medical supplies (splints, etc.), casting supplies and surgery deposits.

Please note if therapy is ordered by the physician, a separate co-payment may apply.

Initial:_____

Insurance

1. If insurance information is not provided at the time of service, you will be considered a "self-pay" patient and you will be expected to pay at the time of your visit.
2. If your insurance company requests an accident report to be completed, you ***MUST*** complete the form and return it to them even if your claim is not accident related.
    a. Failure to comply with theis request will result in a denial from your insurance company. If this occurs, you will be held responsible for your entire balance.

Initial:_____

Secondary Insurance Policy

(including Medicare beneficiaires)

1. Secondary Insurances are billed ***ONE TIME*** **as a courtesy.**
2. Patient will be responsible for the balance 4 weeks after billed date.
3. Secondary will not be rebilled for any reason.
4. We will provide you with instructions on how to be reimbursed by your secondary insurance if you desire to pursue matters further.

Initial:_____

By signing below, you are accepting your responsibility for your services and are stating that you understand our policies and your responsibilites.

Patient/Guardian signature: _____Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in following manner:

(Please place a √ - mark next to all that apply)

____ Home Telephone: _____

____ O.K. to leave message with detailed information

____ Leave message with callback number only

___ Written communication

____O.K. to mail to my home address

____O.K. to mail to my work office address

____O.K. to fax to this number: _____

____Work Telephone: _____

____ O.K. to leave message with detailed information

____ Leave message with callback number only

____Other _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

I, _____hereby authorize the Bronstein Hand Center (BHC) to disclose my protected healthcare information to *_____, _____, _____, And _____. I am fully aware that once the information is released to the above named person, BHC will not be held liable for any misuse of the information given.

(Example: Spouse's name, child, relative etc.)

_____ _____

Patient/Patient's guardian signature Date

_____ _____

Printed name Birthdate