COMPREHENSIVE HAND SURGERY CENTER, P.C.

PLEASE PRINT

Patient's Name _____ Sex M F Marital Status _____
(First) (M.I.) (Last)

Address_____Apt # _____ City _____ State ___ Zip _____

Home Phone (___)_____Social Security #____-___-_____Date of Birth___/___/_____.

Cell Phone (___)_____. (If patient is a minor, provide parent's employment information)

Employer _____ Work Phone: (___)_____.

Employer's Address_____City_____State_____Zip_____.

How long employed there?_____ If less than 6 months, Prior Employer _____

Prior Employer Address_____ City_____ St___ Zip_____Phone_____

Name of Spouse (or parent if under 18)_____

Spouse or parent employment _____

Address_____City_____State_____Zip_____.Phone _____.

Responsible party (if patient is minor):_____ Phone (___)_____

Address_____ City _____ State _____ Zip _____

If patient is a minor and parents are not living together, please provide information for other parent:
Name of other parent _____

Address_____City_____State_____Zip_____.Phone _____.

Other parent employment _____

Address_____City_____State_____Zip_____.Phone _____.

Who may we thank for referring you to our office? _____

Insurance coverage: Work Comp_____ Auto Accident _____ Health Insurance _____

(If injury IS work related, fill out Work Comp section. If injury is NOT work related fill out Medical/Commercial sections only)

If accident, Time of accident:___:___AM/PM Date:_____Date you first saw a doctor about this?_____

Workers' Comp Insurance:_____Claim#:_____

Work Comp Carrier address _____ City_____ State ___ Zip _____

Adjuster Name:_____Adjuster Phone No.:_____

Medical/Commercial Insurance Policy #:_____Group #:_____

Insurance Company Name:_____Phone # :_____

Insurance Company Address:_____City:_____State, Zip: ____

Subscriber Name:_____Relationship to Patient:_____

Secondary Insurance Policy #:_____Group #:_____

Insurance Company Name:_____Phone # :_____

Insurance Company Address:_____City:_____State, Zip: ____

Subscriber Name:_____Relationship to Patient:_____

AUTHORIZATION FOR TREATMENT, INFORMATION; RELEASE AND ASSIGNMENT OF BENEFITS:

I, the patient, parent of the patient, or legal guardian of the patient, authorize Comprehensive Hand Surgery Center and its staff to render medical treatment to my child or me. I hereby authorize Comprehensive Hand Surgery Center to release medical information to the insurance company(ies) and attorney listed above or to my attorney. I hereby assign Comprehensive Hand Surgery Center all money that I recover as a result of the accident or illness for which I am being treated until all amounts due are paid in full. I recognize that my insurance policy is a contract between my insurance company and me and that I am personally responsible to Comprehensive Hand Surgery Center for ALL charges for services rendered or goods provided. Although I may be represented by an attorney on matters related to the illness or injury for which Comprehensive Hand Surgery Center has rendered services to me, I must still keep my account on a current basis.

As a courtesy to me, Comprehensive Hand Surgery Center will bill and collect from my insurance company; however Comprehensive Hand Surgery Center will not be responsible for lost or misplaced insurance claims. I understand that Comprehensive Hand Surgery Center may not accept the amount my insurance company states are "usual and customary fees " (UCR) as payment in full. I may get a bill for deductibles, co-payments, co-insurance and non-covered amounts. I may have a balance due after insurance payments. Comprehensive Hand Surgery Center will provide treatment and supplies it deems medically necessary, proper and helpful for the treatment of my condition. If my insurance company refuses to pay for such treatment or supplies or deems them not medically necessary in its judgment, I agree to accept and pay a direct bill from Comprehensive Hand Surgery Center for such treatment or supplies. Medicare and certain other insurance companies will not pay for some specific supplies or procedures, including hand and wrist splints. By signing this form, I recognize that my insurance carrier may not pay for the splint, and if one is issued to me I will receive a bill from Comprehensive Hand Surgery Center for this item/service. If pre-authorization or referrals from other doctors are required by my insurance carrier, it is my responsibility to obtain these, and this must be completed prior to receiving treatment. If payment from my insurance company is not received by Comprehensive Hand Surgery Center within 75 days from the date of service, the TOTAL balance will become my responsibility and will be due immediately. Any payments for treatment not received by Comprehensive Hand Surgery Center or its agent within 90 days from the date of service will be referred to an attorney and/or other agency for collection. If my account is referred to a collection agency, a credit agency or an attorney for collection, I agree to pay collection or attorney's fees of thirty five percent (35%) of the total debt plus court costs and interest at a rate of one and one-half percent (1.5%) per month on the unpaid balance from the date that payment was first due.

If anyone at Comprehensive Hand Surgery Center is exposed to my (or my child's) body fluids (including blood) that may transmit HIV or Hepatitis or other infectious diseases, I (or my child) will submit to blood tests as provided under Virginia law.

If I or any attorney or other party representing me contends at any time that some entity or third party is liable to me for money damages (for example, any type of negligence claim, automobile accidents, product liability claim or other accident claim), I agree that Comprehensive Hand Surgery Center is entitled to bill and collect in full any balance due for services or supplies rendered to me or my minor child. I agree to permit Comprehensive Hand Surgery Center to place a lien against any proceeds of such claim, whether obtained or to be obtained by litigation, negotiation, arbitration, mediation or otherwise, for services or supplies rendered to me by Comprehensive Hand Surgery Center. In the event Comprehensive Hand Surgery Center is obligated to return insurance payments it has received on my behalf (or my child's behalf) to any insurer or third party, due to any subrogation or reimbursement agreement or law, I agree to be personally liable to pay for all treatment and/or supplies rendered to me without discount or UCR deductions.

If any of my treatment prior to today was by a Comprehensive Hand Surgery Center physician(s) at a hospital emergency department, operating room, or other care facility, I agree that the terms of this agreement, including those relating to overdue accounts and collection, apply to both my earlier surgery, care and treatment, the charges I incurred, and the charges for my follow-up care today and afterward.

Signature of patient/parent or legal guardian of patient _____

Date

Witness _____

Date

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any and all information requested regarding my current address or telephone number, employer or employment information, or any other information sought by Comprehensive Hand Surgery Center or its bona fide agents working its behalf, including but not limited to its attorneys. In the event the patient is a minor, this paragraph applies equally to one or both parents or legal guardians.

Signature of patient/parent or legal guardian of patient _____

Date

Witness _____

Date

MEDICAL INFORMATION:

The American Recovery and Reinvestment Act of 2009 requires physician offices to collect the following data:
Race: White ☐ Black ☐ Asian ☐ Indian/Alaskan ☐ Pacific Islander ☐ Declined ☐
Ethnicity: Hispanic ☐ Non-Hispanic ☐ Declined ☐

Describe your symptoms:

_____
_____
_____

Which hand/arm? R L
Did your condition come on gradually? Y ☐ N☐
Was there an accident involved? Y ☐ N☐
If yes: Date _____ Describe the accident/circumstance_____
_____
_____
_____

PAST MEDICAL HISTORY: Please answer ***all*** questions Y or N

Have you had:	**Y**	**N**
High Blood Pressure?	☐	☐
Diabetes?	☐	☐
Heart Attack?	☐	☐
Thyroid problems?	☐	☐
Disorders of the nervous system?	☐	☐
Liver/Kidney problems?	☐	☐
Tumors?	☐	☐
Stomach Ulcers?	☐	☐
Prior surgery? (If yes, please list):	☐	☐

_____
_____

Artificial heart valve?	☐	☐
Artificial joints?	☐	☐
Other surgical implants?	☐	☐
Do you smoke cigarettes?	☐	☐

If yes, how many packs per day?_____

Do you drink alcohol?	☐	☐

Occasional___ Moderate___ Excessive___

List all medications you currently take, including dose:

_____
_____
_____
_____
_____

Do you have any allergies to medicines?
Y ☐ N☐
If yes, please list:

_____
_____
_____

Are you currently receiving treatment for any other condition(s)? Y ☐ N☐
If yes, please list:

_____
_____
_____

Have you had any prior surgeries? ☐ ☐ If yes, lease list: _____
_____
_____

Are you being treated for any other medical condition? ☐ ☐ If yes, lease explain:_____
_____
_____