PATIENT REGISTRATION/INFORMATION

Name:_____Date of Birth_____

Social Security #:_____-_____-_____ Driver License #_____Age:_____Height:_____ Sex: M/F/T

Address:_____City, State, Zip:_____

Home Phone #:_____Cellular Phone #:_____Work Phone #:_____

Referring Physician: _____Referring Physician #:_____

Primary Care Doctor: _____Primary Care Doctor #: _____

Patient's Employer: _____Employer Phone #: _____

Were you injured at work? _____If yes, how? _____Date of Injury: _____

SPOUSE OR PARENT INFORMATION

Name: _____Birthdate: _____

Social Security #:_____-_____-_____ Sex: M/F Phone #:_____Marital Status: _____

EMERGENCY CONTACT INFORMATION

In Case of Emergency Contact: Name: _____ Phone #: _____

Relationship: _____

PRIMARY INSURANCE INFORMATION

Company Name: _____ID#_____ Group #:_____

Member Name: _____ Social Security #:_____-_____-_____

Date of Birth: ____/_____/_____ Insurance Address: _____

City, State, Zip:_____ Phone #:_____

SECONDARY INSURANCE INFORMATION

Company Name: _____ID#_____ Group #:_____

Member Name: _____ Social Security #:_____-_____-_____

Date of Birth: ____/_____/_____ Insurance Address: _____

City, State, Zip:_____ Phone #:_____

Do you use a pharmacy exclusively? If so, please list the name and phone number: _____

I hereby grant permission to Advanced Hand and Plastic Surgery Center, LLC to employ such medical and surgical procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the hold of medical or other information to release to my insurance carrier, any information needed for this or related insurance claim. I agree to pay any charges incurred by me to the Advanced Hand and Plastic Surgery Center, LLC.

I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case for use in examination, testing, credentialing, and/or presentations purposes by Advanced Hand and Plastic Surgery Center, LLC.

_____ _____

SIGNATURE OF PATIENT (PARENT IF PATIENT IS A MINOR) **DATE**

ADVANCED
HAND & PLASTIC SURGERY CENTER

Patient Medical History Form

Patient Name:_____ **Date:**_____

- **Primary Reason for Today's Visit (**Please Check All That Apply):

☐**Initial Consult**	☐ **Hospital Follow-Up**			
☐**Broken / Fractured Arm**	☐ **Right**	☐ **Left**	☐ **Both**	
☐**Broken / Fractured Wrist**	☐ **Right**	☐ **Left**	☐ **Both**	
☐**Broken / Fractured Finger**	☐ **Right**	☐ **Left**	☐ **Both**	**Which Finger:**_____
☐**Wrist Pain**	☐ **Right**	☐ **Left**	☐ **Both**	
☐**Hand Pain**	☐ **Right**	☐ **Left**	☐ **Both**	
☐**Carpal Tunnel**	☐ **Right**	☐ **Left**	☐ **Both**	
☐**Numbness / Tingling in Hands**	☐ **Right**	☐ **Left**	☐ **Both**	
☐**Cyst**	☐ **Right**	☐ **Left**	☐ **Both**	**Where:**_____
☐**Laceration**	☐ **Right**	☐ **Left**	☐ **Both**	**Where:**_____
☐**Other:** _____	☐ **Right**	☐ **Left**	☐ **Both**	**Where:** _____

- **How and When Did This Injury Occur:** _____

- **Medications** (Please Check All That Apply) **I AM NOT TAKING ANY MEDICATION**

☐**Albuterol**	☐**Coumadin**	☐**Hydrocodone**	☐**Lortab**	☐**Plavix**
☐**Aspirin**	☐**Crestor**	☐**Insulin**	☐**Metformin**	☐**Tetracycline**
☐**Augmentin**	☐**Keflex**	☐**Metoprolol**	☐**Oxycodone**	☐**Toprol**
☐**Celebrex**	☐**Glyburide**	☐**Lasix**	☐**Oxycontin**	☐**Ultram**
☐**Cephalexin**	☐**HCTZ**	☐**Lipitor**	☐**Penicillin**	☐**Zoloft**

Other: _____

Currently in Pain Management ☐**No (Initial):**_____ ☐**Yes (Initial):**_____ **Doctor Name:**_____

- **Medical History (**Please Check All That Apply): ☐**NO MEDICAL PROBLEMS**

☐**Anxiety**	☐**Depression**	☐**Kidney Problems**
☐**Asthma**	☐**Diabetes (Type 1 / Type 2)**	☐**Lung Problems**
☐**Bipolar**	☐**Heart Problems**	☐**Peripheral Vascular Disease**
☐**Cancer**	☐**High Blood Pressure**	☐**Rheumatoid Arthritis**
☐**COPD**	☐**High Cholesterol**	☐**Thyroid Problems**

Other: _____

Allergies (Please Check All That Apply): ☐**NO KNOWN DRUG ALLERGIES / NKDA**

☐**Ciprofloxacin**	☐**IV Dye**	☐**Sulfa Drugs**
☐**Codeine**	☐**Latex**	☐**Tape**
☐ **Erythromycin**	☐**Penicillin**	☐**Tetrocycline**
☐ **Iodine**	☐**Steroids**	☐**Tylenol**

Other: _____

- **Please let us know how you were referred to our office:**
  - ☐ **Hospital/Emergency room: Which Hospital/ER were you treated at?_____**
  - ☐ **Established Patient**
  - ☐ **Insurance referral**
  - ☐ **Internet**
  - ☐ **Patient/Friend/or Relative formerly treated or currently being treated at AHAPSC**
  - ☐ **Physician Referral by Dr._____**
  - ☐ **Primary Care Physician**
  - ☐ **Self-Referral**
  - ☐ **Urgent Care Clinic: Which Urgent Care Clinic were you treated at?**
  - ☐ **Other:_____**

Family History:

- **Mother**

  (Please circle one): **Alive** **Deceased** **Unknown**

  (Please check all that apply): ☐ **Diabetes** ☐ **Hypertension** ☐ **Cancer (please specify):_____**

  ☐ **Stroke** ☐ **Heart Disease** ☐ **Mental Illness** ☐ **Unknown**

  ☐**Other: _____**
- **Father**

  (Please circle one): **Alive** **Deceased** **Unknown**

  (Please check all that apply): ☐ **Diabetes** ☐ **Hypertension** ☐ **Cancer (please specify):_____**

  ☐ **Stroke** ☐ **Heart Disease** ☐ **Mental Illness** ☐ **Unknown**

  ☐**Other: _____**

- **Past Surgical History** (Please Check All That Apply**):** **□NO SURGERY**

□Adenoidectomy	**□Hysterectomy**	**□ Breast Biopsy**	**□ Elbow**
□Angioplasty	**□Neck Surgery**	**□Right**	**□Right**
□Appendectomy	**□Oral Surgery**	**□Left**	**□Left**
□Back Surgery	**□Prostate Surgery**	**□Both**	**□Both**
□Cosmetic Surgery	**□Reconstructive Surgery**	**□ Carpal Tunnel**	**□ Knee**
□C-Section / Cesarean	**□Stent Placement**	**□Right**	**□Right**
□Endoscopy	**□Stomach Surgery**	**□Left**	**□Left**
□Eye Surgery	**□Thyroid Surgery**	**□Both**	**□Both**
□Gall Bladder Removal	**□Tonsillectomy**	**□ Cubital Tunnel**	**□ Shoulder**
□Gastric Bypass	**□Trigger Finger Release**	**□Right**	**□Right**
□Heart Surgery	**□Tubal Ligation**	**□Left**	**□Left**
□Hemorrhoid Surgery	**□Vasectomy**	**□Both**	**□Both**
□Hernia Surgery	**□Wound Care**		

Other: _____

- **Past Hospitalizations (over 24 hours): □NO □Yes**
  If YES, please state reason(s):_____

SOCIAL HISTORY:

□ Smoke Cigarettes or Cigars
- **□ Never smoker**
- **□ Former smoker**
- **□ Occasional**
- **□ ½ pack/day**
- **□ 1 pack /day**
- **□ 2 or more/day**

□ Drink Alcohol
- **□ No**
- **□ Yes**

If yes: □ Socially
- **□ Everyday**

EMPLOYMENT:

□ Disabled (state reason**):**_____

□ Accounting	**□ Management**	**□ Office Work**
□ Cleaning Services	**□ Medical**	**□ Student**
□ Construction	**□ Retired**	**□ Teacher**
□ Law Enforcement	**□ Sales**	**□ Unemployed**

- **Review of Systems:** (Please Check All That Apply):

□Back Pain	**□Elbow Pain**	**□Shoulder Pain**
□Joint Pain	**□Right**	**□Right**
□Joint Stiffness	**□Left**	**□Left**
□Joint Swelling	**□Both**	**□Both**
□Neck Pain		

□Radiating Pain from Hand to Extremity
- **□Right**
- **□Left**
- **□Both**

Numbness / Tingling in the Hand(s)
Does it get worse at night?
- **□Yes**
- **□No**

Consent for Treatment: The undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by the physicians of Advanced Hand and Plastic Surgery Center, LLC deemed advisable and necessary in the diagnosis and treatment of any condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records for treatment. I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case for use in examination, testing, credentialing, and/or presentations purposes by Advanced Hand and Plastic Surgery Center, LLC.

Signature of Patient: _____ **Date:** _____

Notice of Privacy Practices

I, _____have had the opportunity to read and review the Notice of Privacy Practices for Advanced Hand and Plastic Surgery Center. All of my questions regarding HIPAA and the use of my protected health information have been answered to my satisfaction.

Patient Signature:_____

If patient is a minor, Parent or Guardian Signature:_____

Date:_____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION PERTAINING TO MY HEALTH TO THE FOLLOWING:

List Person or Persons:

1._____

2._____

3._____

4._____

Patient Signature:_____

Advanced Hand and Plastic Surgery Center, LLC

Ph.(813)866-4426 F. (813) 972-8866

Financial Policy

Thank you for choosing Advanced Hand and Plastic Surgery Center, LLC to serve you and your family's health needs. We are pleased to participate in your family's health care and look forward to establishing a lasting relationship as your hand care specialist. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our financial policy.

Your medical insurance is a contract between you and your insurance company. We can often help with providing information to help you in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with Advanced Hand and Plastic Surgery Center, LLC. Please review and sign the following financial policy.

This is an agreement between Advanced Hand and Plastic Surgery Center, LLC, as creditor, and the patient/debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Advanced Hand and Plastic Surgery Center, LLC.

By executing this agreement, you are agreeing to pay for all services that are rendered.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the balance, any new charges to the account and the finance charge, if any.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to your account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary and secondary (if applicable) insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance, including co-payment, co-insurance and other services. Co-payments and co-insurances will be collected at the time of service. We will also collect co-insurance and deductible amounts prior to any surgical procedures. Please note that the amounts collected are ONLY estimates and it is your insurance company that will determine the exact amount due once your claim has been processed. We will estimate balances to the best of our ability.

Missed Appointment Fee: When a patient does not show up for an appointment, or cancels with less than 24 hours notice, a $25 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be discharged from the practice and asked to seek care from another physician.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorneys' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Hillsborough County, Florida.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, if you want to have copies of your records. You authorize us to include all relevant information, including your payment history upon request. If you are requesting your records to be transferred from another physician or organization to us, you authorize to receive all relevant information, including your payment history.

FMLA (Family Medical Leave Act)/Disability Paperwork: There is a $25.oo fee, due upon receipt of paperwork, for completion of all disability and/or FMLA paperwork.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit, preferably a notice of injury. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance, in the absence of insurance; other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Failure to comply with this financial policy could result in discharge from this practice.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Divorce Decrees: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Print Patient's Name: _____

Responsible Party

(If not the patient)_____

Signature:_____

Date:_____

ADVANCED
HAND & PLASTIC SURGERY CENTER

MEDICAL DETAIL REPORT

***This form must be filled out for insurance purposes. If it is left blank there is the possibility of your insurance company denying coverage.**

Patient name: _____

ID#/SSN: _____

When did hand problem start? : _____

Describe **reason** for today's visit: _____
_____
_____

How did hand problem occur? : _____
_____
_____
_____

Where did hand problem occur? (ie: home, friend/relative's home, work, store, car accident, etc...)

_____
_____
_____

Did patient have any **other** insurance coverage?

_____
_____
_____

Is there any **responsible party** for this injury/accident?

_____
_____
_____

Patient/Legal Responsible Signature: _____Date: _____

Office Staff Witness: _____ Date: _____