



345 Main Street  
Suite 202  
Madison, NJ 07940

620 Essex Street  
Suite 202  
Harrison, NJ 07029

Ph: (973) 947-4700  
Fax: (888) 900-9262  
HandArmSurgery.com

## **CONFIDENTIAL PATIENT INFORMATION**

Date of Visit: \_\_\_\_\_

**Physician:** \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Apellido) (Nombre) (Fecha de Nacimiento)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(Direccion) (Ciudad) (Estado) (Codigo Postal)

Phone #: (C) \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_  
(Telefono) (Celular #) (Casa #) (Trabajo #)

Email: \_\_\_\_\_ @ \_\_\_\_\_

SS#. \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Marital Status: Married Single Widowed Divorced/Separated  
Seguro Social# (Sexo circule uno) (Estado Civil circule uno)

Employer: \_\_\_\_\_  
Nombre y Direccion de Empleador (Name) (Address)

Referred by: \_\_\_\_\_  
(Referido Por) (Name) (Nombre) (Address) (Direccion)

**Primary/Family Physician:** \_\_\_\_\_  
(Primario/Medico de la Familia) (Name) (Nombre) (Address) (Direccion) (Tel. #)

Parents' names if under 18: \_\_\_\_\_  
(Los padres si es menor de 18)

Mother's SS #: \_\_\_\_\_ Father's SS #: \_\_\_\_\_  
(Madre SS #) (Padre SS #)

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel. #: \_\_\_\_\_  
(Contacto de emergencia) (Relacion) (Telefono #)

Pharmacy name: \_\_\_\_\_ Address: \_\_\_\_\_  
Tel. #: \_\_\_\_\_

Check this box if you prefer NOT to receive appointment reminders via text, email, or voice message.



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**Medical History**

Date of Visit: \_\_\_\_\_

PRN: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_

DOB: \_\_\_\_\_

**Reason for your visit:** \_\_\_\_\_

Which hand/arm is affected?      Right      Left      Both

Which hand is your dominant hand?    Right      Left

How long have you had the problem? \_\_\_\_\_

How do you rate your pain (Circle one):    no pain    1    2    3    4    5    6    7    8    9    10    severe pain

intermittent    constant    sharp    dull    stabbing    burning    electric    daytime    nighttime    activity-related

Does anything improve your pain? \_\_\_\_\_

Have you had prior treatment for this problem? \_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_ Are you CURRENTLY working? yes / no

Smoking: Never    Former    Current    \_\_\_\_\_ pack(s)/day: \_\_\_\_\_ # years: \_\_\_\_\_

Alcohol: No    Social    Yes    # of drink(s)/day: \_\_\_\_\_

**Past Medical History:** (please circle all that apply to you): [ ]None

- |                     |                   |                       |                |                      |
|---------------------|-------------------|-----------------------|----------------|----------------------|
| Diabetes            | Heart failure     | Gout                  | Liver disease  | HIV Positive         |
| High blood pressure | Vascular disease  | Multiple Sclerosis    | Kidney disease | Depression           |
| High cholesterol    | Aneurysm          | Enlarged prostate     | Sleep apnea    | Glaucoma             |
| Thyroid disease     | Anemia            | Hepatitis: Type A B C | Emphysema      | Rheumatoid arthritis |
| Heart disease       | Bleeding disorder | Gastric Reflux        | Asthma         | Osteoarthritis       |
| Heart attack (MI)   | Seizure disorder  | Stomach ulcer         | Lyme disease   | Stroke               |
- Cancer (types) \_\_\_\_\_

List any other medical conditions you have which are not listed above: \_\_\_\_\_

**Past Surgical History:** \_\_\_\_\_

**Family Medical History:**

Mother: \_\_\_\_\_  
Father: \_\_\_\_\_  
Sibling: \_\_\_\_\_

**Allergies:** \_\_\_\_\_ [ ] No Known Drug Allergy  
\_\_\_\_\_

**Current Medications (with doses):** [ ] None [ ] See List  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Symptoms** (Circle any other issue you are **currently** experiencing): [ ] **NONE**

- General: weight change, change in strength or exercise tolerance, night sweats
- Neck: stiffness, pain, tenderness
- Eyes: vision change, double vision, tearing, blind spot, pain
- Ears: change in hearing, ringing in ear, bleeding, balance disturbance
- Nose: bleeding, obstruction, discharge
- Mouth: dental difficulties, gingival bleeding, use of dentures
- Cardiovasc: chest pains, chest tightness, palpitations, venous stasis
- Respiratory: shortness of breath, wheezing, cough, bloody cough
- GI: change in appetite, difficulty swallowing, abdominal pains, bowel habit changes, bloody stool
- Genitourinary: kidney problems, burning or frequency with urination
- Skin: change in skin mole, rash
- Neurologic: weakness, tremor, seizures, changes in mentation, uncoordinated gait
- Psychiatric: depressive symptoms, changes in sleep habits, changes in thought content
- Hematologic: bleeding tendency, prolonged bleeding, deep vein thrombosis
- Allergic/Immunologic: seasonal or contact allergies

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask us to correct that record. We will not reveal your record to others unless you direct us to do so. You are able to obtain more information by contacting our Office Manager.

Our Notice of Privacy Practices describes more in detail, how your health information may be used and revealed, and how you can obtain your information.

### YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, \_\_\_\_\_, have received a copy of this Office's Notice of Privacy Practice's.  
(Aviso de la Práctica de Privacidad)

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(Firma del paciente o tutor) (Fecha)

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### CONSENT FOR TREATMENT

I hereby authorize the physicians at the *Institute for Hand & Arm Surgery* and whomever they may designate as assistant, to provide all treatment including rehabilitative therapy that is deemed necessary in relation to my present ailment. In order for my doctor to make an appropriate diagnosis, I have provided all necessary information regarding my present complaint, past medical history, hospitalization, medications, and any other information pertinent to my health.

At any time during the course of treatment, I will inform the doctor of any unusual changes to my health.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(Firma del paciente o tutor) (Fecha)

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### Authorization for Use or Disclosure of Patient Photographs and/or Videos

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the *Institute for Hand & Arm Surgery*. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising. I understand that I may revoke this authorization at any time, but such revocation must be in writing. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

I understand that the Institute for Hand & Arm Surgery cannot condition treatment on whether or not I sign this authorization.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(Firma del paciente o tutor) (Fecha)



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## **AUTHORIZATION FOR RELEASE OF PATIENT RECORDS**

I, \_\_\_\_\_, authorize the offices of the *Institute for Hand & Arm Surgery*  
(Patient name/Nombre del paciente)

to disclose to \_\_\_\_\_  
(Person to whom disclosure is made/Persona a la que la divulgación se hace)

my medical records to the following extent:

\_\_\_\_\_  
(treatment dates, name of health care facility which treatment was provided; types of records to be excluded, if any)

for \_\_\_\_\_  
(Purpose of disclosure/Propósito de la divulgación)

**I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV), that my signing this document authorizes Institute for Hand and Arm Surgery to release that information.**

**I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege.**

This consent may be revoked at any time in writing to – *Institute for Hand & Arm Surgery*, except to the extent that the *Institute for Hand & Arm Surgery* has already taken action in reliance on it. If not previously revoked, this consent will terminate upon 99 years from the date signed. *Institute for Hand & Arm Surgery* will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization.

I acknowledge and understand that uses and disclosures of my health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentiality laws.

Signature of patient or guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(Firma del paciente o tutor) (Fecha)



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## Out of Network Notice

**We are out-of-network providers for ALL Commercial Health Benefit Plans.** This notice is to confirm that you have been advised that the physicians at the *Institute for Hand & Arm Surgery* are non-participating with your insurance carrier.

The fee for the office visit and/or surgery will be billed to your insurance company. This fee does not include X-rays, injections, durable medical equipment, casts, therapy, etc, which are additional. The patient is responsible for the difference between what the physician bills out and what the insurance allows.

Since we are out-of-network with your insurance company, please be advised that there is a possibility that check(s) for our services will be sent directly to you. Please endorse these checks, payable to: *Institute of Hand & Arm Surgery* and mailed to our office as soon as possible. It is important that you include the "Explanation of Benefits" sheet with the check(s) to ensure that payment(s) is(are) posted properly to your account. The mailing address is:

Institute for Hand & Arm Surgery  
345 Main Street, Suite 202  
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We can give a receipt for your visit to submit to your insurance carrier, or we would be happy to submit the claim for you, whenever possible.

In the event that surgery is warranted during the course of your treatment, we will contact your insurance carrier. We will obtain a pre-certification for the surgical procedure, verify your benefits and negotiate the surgical fee. However, there may be expenses that may become your responsibility. In addition to the physician's charges, there may be facility, radiology and pathology charges, which are not part of our services.

**Our Affiliated Surgical Facilities are:** Harrison Endo Surgical Center, Overlook Medical Center

If your insurance company denies your claim or does not respond with proper payment in a timely fashion, your excellent assistance will be necessary in the appeal process in reminding your insurance company about their responsibility in making prompt payment.

**The physician(s) at the *Institute of Hand & Arm Surgery* are out-of-network with your insurance.**

I, \_\_\_\_\_, acknowledgment the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## PATIENT FINANCIAL POLICY

Our practice goal is to be your partner in providing care. Letting you know in advance our Financial Policy provides for a good flow of communication and enables us to achieve that goal. **Please read this carefully.** If you have any questions, do not hesitate to ask a member of our staff.

1. We request that you present your current insurance card upon arrival to your initial visit and notify us of any changes on subsequent visits.
2. **According to your insurance plan, you are responsible for any and all co-payments, deductibles, co-insurances and medical services not covered by your plan.**
3. **It is your responsibility to understand your benefit plan** and to know if a written referral or pre-authorization is required. Our staff is available to help.
4. **If we do not participate in your insurance plan or you do not have insurance, payment in full is expected. You agree that payment of insurance benefits for all services rendered to you are to be made on your behalf to Institute for Hand & Arm Surgery. Outstanding balances must be paid prior to a scheduled visit.**
5. **Certain insurance carriers will send our payment directly to your home address. It is expected that you will forward that payment to our office, along with the Explanation of Benefits.**
6. Co-pays are due at the time of service. A \$10 processing fee may be charged in addition to your co-pay, if the co-pay is not paid at the time of service.
7. We will invoice you after receipt of your insurance plan's Explanation of Benefits if there is a balance due. Your payment is due **10 business days from receipt of your statement.** Any balance past due for 45 days or longer will be turned over to our collection agency unless other payment arrangements have been made with us.
8. **A fee of \$40.00 may be charged if you miss a confirmed appointment or fail to cancel an appointment at least 24 hours in advance.** A new appointment will not be made, unless we have your credit card on file.
9. **Three (3) no shows/same day cancellations within a 12-month period will automatically be terminated from our practice.** Exceptions may be made depending on the specific circumstances.
10. Our secure patient portal is available online. This service allows access to medical records, direct communication with your doctor, and on-line request for appointments.
11. A \$30 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
12. If you have forms to be completed, there is a charge. Payment is due when the forms are dropped off. We require a minimum one-week turnaround time for those forms.
13. **Failure to pay outstanding balance(s) will result in legal collections for the FULL AMOUNT plus 33.33% COLLECTIONS FEES.**

I, \_\_\_\_\_, understand and agree to the Patient Financial Policy.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Responsible Party