OHSA
Orlando Hand Surgery Associates

PLEASE PRINT **ACCOUNT**_____

Patient Name: _____ Date of Birth: _____Age: _____ □ Male □ Female

Address: _____

City: _____ St.____ Zip: _____

Home Phone: _____ Cell or Alternate: _____ Social Security #: _____

Drivers License #: _____ email address: _____

Circle One: Employed Unemployed Disabled Retired

Employer (Patient): _____Occupation: _____

Employer Address: _____Work Phone: _____

RESPONSIBLE PARTY INFORMATION:

Name: _____ Date of Birth:_____ Relationship:_____ Phone:_____

Address: _____City: _____State: ____ Zip: _____

Employer: _____

INSURANCE:

Primary Insurance: _____Customer Service #: _____

Claims Address: _____City: _____State: _____ Zip: _____

Subscriber Name: _____ Date of Birth: _____

Policy #: _____ Group#: _____

Secondary Insurance: _____ Customer Service #: _____

Claims Address: _____City:_____ State:_____ Zip: _____

Subscriber Name: _____Date of Birth: _____Policy #: _____Group:_____

Describe the nature of this visit: _____

Did This Injury occur at work? □ Yes □ No If Yes Date of Injury: _____

Is this Injury due to an Auto Accident? □ Yes □ No If Yes Date of Injury: _____

EMERGENCY CONTACT:

Name: _____ Phone #: _____Relationship: _____

Address: _____City: _____State: _____ Zip: _____

Primary Care Physician: _____Phone#_____

Address: _____

Pharmacy: _____Phone#_____

Address: _____

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Orlando Hand Surgery Associates, P.A. all insurance benefits, payable to me for services rendered. I understand that I am responsible for co-pays, deductibles and/or non covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize **Release of Medical Information** to my insurance carrier, or requested physician to provide continuity of care. I authorize any physician or medical facility that has treated me in the past to release a copy of my records to *Orlando Hand Surgery Associates*. I authorize use of this signature on all insurance benefits. The information I provided is accurate and current.

_____ _____ _____

Print Name Signature of Insured or authorized person, patient or parent Date

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Medical History

Name: _____ **DOB:** _____ **Date:** _____
Height: _____ **Weight:** _____ **Marital Status:** □ **Married** □ **Divorced** □ **Single** □ **Separated**
Race: _____ □ **Widowed** □ **Other**
Primary Language: □ **English** □ **Spanish** □ **Other:** _____
Secondary Language (if applicable): _____
□ **Right handed** □ **Left handed** □ **ambidextrous**
Smoking History: □ **never smoked** □ **current every day smoker** □ **occasional smoker** □ **former smoker**
***Primary Care Physician:** _____
Ph:_____ **Fax:**_____ **Your email:** _____

Medication Allergies: □ **NONE**
□ **Penicillin** □ **Codeine** □ **Aspirin** □ **Sulfa** □ **Erythromycin** □ **Bactrim** □ **Iodine** □ **Latex** □ **Novocain**
□ **Other (please list):**

_____

_____

Current Medications and dosages (□ NONE)

NAME	DOSAGE	NAME	DOSAGE

List all Surgeries, including dates (□ NONE)

Date	Type of Surgery

Briefly Describe the Nature of your visit (and indicate left or right side is applicable):

_____

How long have these symptoms been present? _____

Please indicate if Accident is related to□ Auto Accident, □ Work Related, or □ Other Accident type
Date of Accident: _____ **State / Location of Accident:** _____
If other accident please describe_____

Patient Initials: _____

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Medical History-Page 2

Name: _____ **DOB:** _____ **Date:** _____

Review of Symptoms (identify previous and current medical problems):

Have you ever had or been diagnosed with the following:	Yes/No (Y/N)	Details:
Abdominal Pain		
Anemia		
Anxiety		
Arthritis		
Asthma		
Back Pain		
Bladder Infections		
Bleeding Tendency		
Blood Transfusions		
Bowel Issues		
Bursitis/Tendonitis		
Cancer		
Chest pain		
Chicken Pox		
Circulation problems		
Depression		
Diabetes		
Dizziness/Fainting		
Epilepsy/Seizures		
Erectile difficulties		
Fatigue		
Gallbladder Disease		
Glaucoma/Cataracts		
Gout		
Headaches/Migraines		
Hearing Loss		
Heart Disease		
Heart Murmur		
Heart Palpitations		
Hemorrhoids		
Hepatitis		
Hernia		
High or low blood pressure		
HIV/ AIDS		
Indigestion/ Heartburn		
Insomnia		
Kidney Disease		
Leg pain/swelling		
Measles/ Mumps		
Neck Pain		
Osteoporosis		

Pneumonia		
Polio		
Prostate problems		
Rectal Bleeding		
Ringing in ears		
Shortness of Breath		
Sleep Apnea		
Stroke		
Thyroid Disease		
Tuberculosis (TB)		
Ulcers		
Weight Gain/ Loss		
Wheezing		
SOCIAL HISTORY		
Live alone?		
Drink alcohol?		
Drink caffeinated drinks		
Employed?		
Exercise?		
Stress?		
FAMILY HISTORY		
I have family history of the following:		
Bleeding Disorder		
Cancer (any type)		
Diabetes		
Epilepsy/ Seizures		
Glaucoma		
Heart disease		
High Blood Pressure		
Kidney Disease		
Stroke		

Please provide any other medical history that can be pertinent to provide you the safest care:

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to *Orlando Hand Surgery Associates, P.A*. all insurance benefits, payable to me for services rendered. I understand that I am responsible for co-pays, deductibles and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize **Release of Medical Information** to my insurance carrier, or requested physician to provide continuity of care. I authorize any physician or medical facility that has treated me in the past to release a copy of my records to Orlando Hand Surgery Associates. I authorize use of this signature on all insurance benefits. The information I provided is accurate and current.

Print Name **Signature of Insured or authorized person, patient or parent** **Date**

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801 N. Orange Ave, Suite 600, Orlando, FL 32801

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____ **Date of Birth:** _____
Social Security #: _____

Purpose/Need for Information:

☐ Application for Insurance ☐ Changing Physicians ☐ Personal

☐ Regarding Insurance Claim ☐ Specialist

Specific Documentation Required:

☐ Office Notes ☐ Other _____

☐ Laboratory Reports _____

☐ X-Ray Reports _____

Information Requested From:

_____
_____
_____

Forward Documentation To:

_____
_____
_____

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to me during the period: FROM_____ TO _____.

☐ **PLEASE DO NOT FAX RECORDS**

This request is authorized to include and Federal and/or State protected information under Florida Statutes 394.459(9) Psychiatric Information, 397.053/396.112 Drug and/or Alcohol Abuse Information, 381.609 HIV and Aids related conditions and/or 397.501(3) records of a minor client.

I understand this authorization will expire 90 days from the date of signature below or when accepted upon, whichever event occurs first. I hereby release to the forwarding addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed.

_____ _____
(Signature or parent/guardian) (Witness)

_____
(Relationship to Patient)

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Notice of Privacy Practices
Acknowledgement of Receipt Form

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Privacy Notice, the terms of our notice may change. If we change our Privacy Notice, you may obtain a revised copy at our practice or by requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Privacy Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name

(Print): _____

(Signature): _____

Date: _____

Witness: _____

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FINANCIAL POLICY

Thank you for choosing Orlando Hand Surgery as your health care provider. We are committed to the success of your treatment. The medical services provided by our office are services you have elected to receive which imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not been met. You are also responsible for any co-payments which are usually 20% of the allowed amount for an item or service.

COPAYMENTS AND DEDUCTIBLES: **All co-payments and deductibles must be paid in full at the time of service**. This arrangement is part of your contract with your insurance company

SELF PAY: Payment in full is due at the time of service if you do not have health insurance.

NON-COVERED SERVICES: Please be aware that some services you receive may not be covered or not considered reasonable or medically necessary by Medicare or other insurance carriers. You are responsible for payment of these services.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan, which may require a referral from your primary care physician prior to your appointment when visiting a specialist office. Therefore, if a referral is required and not presented at the time of your visit your appointment will be rescheduled or you will be financially responsible for services received due in full upon completion of the visit.

CLAIM SUBMISSION: As a courtesy service to you, we will submit your insurance claims for the services rendered in our office and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three statements for your financial responsibility after your insurance has processed Claims. After the third notice your account may be forwarded to a Collection Agency. If you account is assigned to an outside collection agency an additional fee of 40% of the amount owed will be added. Please let the billing department know if you have difficulties resolving your bill. Payment arrangements may be considered on a case to case basis.
We accept MasterCard and Visa for your convenience.

FORM COMPLETION: There is a $15.00 per form charge for any forms you request that the doctor complete. This Fee must be paid prior to form completion. It can take up 72 hours for the forms to be completed.

PAYMENT POLICY: All balances will be due in full at the time of your office visit whether or not you have received a statement from our office. We will provide you with a copy of your bill and the insurance credits upon request.
There is a $35.00 charge for checks returned unpaid by your bank.
We reserve the right to charge a $50.00 fee for missed appointments and an additional charge for surgical appointments.
If you are unable to make your appointment please cancel/reschedule at least 24 hours in advance.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and/or Contact information. I understand and accept these terms.

PRINT Patients Name: _____ Signature:_____

PRINT Responsible Party's Name: _____ Signature:_____

Relationship to Patient: _____ Date:_____

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Authorization to Release or Use Information for Treatment, Payment, or Health Care Operations

I hereby authorize the release or use of my individually identifiable health information and medical record information by Orlando Hand Surgery Associates, P.A. in order to carry out treatment, payment or health care operations. Your should review The Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this form.

We reserve the right to change the terms of our Notice of Privacy Practices at any time. If we do make changes to the terms of our Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how you protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then biding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and Medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:
_____
_____

I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

_____ Via e-mail to the Patient's designated e-mail address which is (I am responsible for notifying the practice of any Changes to my e-mail address) _____

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.

_____ Via telephone, if I contact the practice and provide the appropriate information (including my name, social Security number, and unique personal identifier)

_____ Via fax to my designated fax number which is _____

_____ At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice IN WRITING. The revocation shall be effective except to the extent that the Practice has already taken action based on a prior consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign the Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am that Patient or the authorized party to act on behalf of the Patient to sign this document verifying consent to the above terms.

_____ Date:_____
Signature of Patient or Authorized Representative

_____
Please PRINT Name

• Please explain Representative's relationship to the Patient and include a description of Representative's Authority to act on behalf of the Patient.

_____
_____
_____