CHICAGO HAND & ORTHOPEDIC SURGERY CENTERS

Paul E. Papierski, MD
Taruna Madhav Crawford, MD
Gregory E. Crovetti, MD
Socrates A. Brito, MD
Savan D. Patel, MD
Kerri A. Kulovitz, DO

PATIENT REGISTRATION FORM

Account #:_____

All forms must be completed and signed prior to treatment.

GENERAL INFORMATION

Patient Name:_____
First Middle Last

Address:_____
Street City State Zip

Home Phone No:_____ Work Phone No:_____

Cell Phone No:_____ Email Address:_____

Date of Birth:_____ Social Security Number:_____ Gender: Male Female
(Circle One)

Race:_____ Ethnicity:_____ Preferred Language:_____

Primary Care Physician Name:_____Phone No: _____ City: _____

Referring Physician Name_____ Phone No:_____ City:_____

Is this visit for the purpose of: Workman's Compensation Motor Vehicle Accident Personal Injury Self-Pay
(Circle One)

Marital Status: Single Married Widowed Divorced Student: Full time Part time
(Circle One) (Circle One)

Spouse Name:_____

Spouse Date of Birth:_____ Spouse Social Security Number:_____

PLACE OF EMPLOYMENT

Name of Patient / Primary Guarantor's Employer:_____ Phone No:_____

Address:_____
Street City State Zip

Name of Spouse / Secondary Guarantor's Employer:_____ Phone No:_____

Address:_____
Street City State Zip

Is this a work related injury? (Circle One) Yes No If you answered yes, please fill out the Workman's Compensation Information Form included in the Patient Registration Packet.

INSURANCE INFORMATION

Name of Primary Insurance Company:_____ Phone No: _____

Mailing Address:_____
Street City State Zip

Policy Holder's Name: _____ ID No: _____Group No: _____

Relationship to Patient: _____ Date of Birth:_____ Social Security Number:_____

Name of Secondary Insurance Company:_____ Phone No:_____

Mailing Address:_____
Street City State Zip

Policy Holder's Name: _____ ID No: _____Group No:_____

Relationship to Patient:_____ Date of Birth:_____ Social Security Number:_____

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Patient Name:_____Account #:_____

GUARANTOR INFORMATION ☐ Check and fill out this section **ONLY IF PATIENT IS A MINOR.**
THIS SECTION MUST BE COMPLETED BY THE **PARENT(S)/GUARDIAN(S)** THAT IS AUTHORIZING TREATMENT

Primary Guarantor/Parent/Guardian Name:_____

Address (If different from above):_____
Street City State Zip

Home Phone No:_____ Work Phone No:_____

Relationship to Patient:_____ Date of Birth:_____ Social Security Number:_____

Secondary Gurantor/Parent/Guardian Name:_____

Address (If different from above):_____
Street City State Zip

Home Phone No:_____ Work Phone No:_____

Relationship to Patient:_____ Date of Birth:_____Social Security Number:_____

PLEASE PROVIDE VALID PICTURE ID & PRIVATE INSURANCE CARD

CONSENT TO HEALTH CARE SERVICES

I, the undersigned Patient, or undersigned person responsible for consenting on patient's behalf hereby request and consent to Chicago Hand & Orthopedic Surgery Centers to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the Patient's care. I hereby acknowledge that all information provided herein is true to the best of my knowledge.

I hereby assign, transfer and set over to Chicago Hand & Orthopedic Surgery Centers all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization and give written notice.
I understand that my copay, if applicable, is due prior to being seen and if my co-pay is not paid Imay have to reschedule my appointment.

I understand that all cancellations of appointments must be made at least 24 hours in advance and rescheduled within the same business week whenever possible. I understand that there will be a $10.00 charge for all appointments cancelled with less than 24 hours' notice, unless the appointment is rescheduled. I understand that there will be a $25.00 charge for all appointments missed with no call made cancelling the appointment. I also understand that three consecutive no show appointments may result in a discharge from Chicago Hand & Orthopedic Surgery Centers.

I hereby agree to pay the regular charges of the physician for any treatment performed on my behalf or authorized by me.
I understand that I am financially responsible for all charges whether or not they are covered by my insurance plan or fall into the insurance company's definition of usual and customary. Chicago Hand & Orthopedic Surgery Centers is committed to providing the best treatment possible for our patients and our charges are considered usual and customary for our area. I understand that all bills are to be paid in full within 45 days of submission to my insurance company. Chicago Hand & Orthopedic Surgery Centers does not wait for the settlement of lawsuits. Interest of 1½% per month up to 9% annually will be charged after 60 days. An authorized, approved payment plan will eliminate interest charges and collections. I understand that I am responsible for all costs of collection for any outstanding fees, including but not limited to any attorney fees, court costs, expenses and interest incurred from the date of my initial consultation with any physician at the Chicago Hand & Orthopedic Surgery Centers.

_____ _____
Patient / Primary Guarantor / Parent / Guardian Signature Date

_____ _____
Spouse / Secondary Guarantor / Parent / Guardian Signature Date

_____ _____
Private Insurance Policy Holder's Signature Date

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HEALTH HISTORY

Name:_____ DOB:_____ Height:_____ Weight:_____

Occupation: _____

Hand Dominance (right or left):_____ Area Affected (e.g. right hand):_____

Reason you were referred here: _____

Date of Injury:_____ How long have you had this condition?: _____

Is this injury or condition work related? _____

Have you been treated for this condition before? Yes No If yes, list treatment:_____

_____

Do you have any of the following diseases?

YES	NO	(Please check all that apply)			
____	____	Asthma / Bronchitis	____	____	Stomach Ulcer / GERD
____	____	Emphysema	____	____	Liver Problem _____
____	____	Respiratory Disease	____	____	Kidney Problem_____
____	____	Tuberculosis	____	____	Hepatitis A B C D E
____	____	Anemia	____	____	Diabetes
____	____	High Blood Pressure	____	____	Thyroid Hyper / Hypo
____	____	High Cholesterol	____	____	Arthritis
____	____	Heart Problem / Pacemaker	____	____	Gout
____	____	Bleeding Problem	____	____	Epilepsy/Seizure Disorder
____	____	Blood clot / DVT	____	____	Cancer _____
____	____	Stroke	____	____	Other_____
____	____	Family History of Anesthesia Problems	____	____	Family History of Diabetes
____	____	Family History of Bleeding Problems	____	____	Family History of Heart Disease

Please list all medications you are taking:

Medications	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications / latex / metals? YES ____NO ____ If yes, what: _____
Do you smoke? YES ____NO ____ If yes, how much: _____
Do you drink alcohol? YES ____NO ____ If yes, how much: _____

Past Surgeries: YES NO What kind / Date Performed: _____

_____

Have you had a tetanus shot? YES NO If yes, when? _____

Patient's Signature:_____ Date:_____

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HEALTH HISTORY

Name;_____ DOB: _____

Please circle symptoms that you currently have or have had in the **past 3 months**:

GENERAL

YES	NO	
____	____	Chills
____	____	Depression
____	____	Dizziness
____	____	Fainting
____	____	Fever
____	____	Fever
____	____	Headache
____	____	Loss of sleep
____	____	Weight loss
____	____	Weight gain
____	____	Nervousness
____	____	Sweats

GASTROINTESTINAL

YES	NO	
____	____	Poor appetite
____	____	Bloating
____	____	Constipation
____	____	Diarrhea
____	____	Nausea
____	____	Rectal bleeding
____	____	Stomach pain
____	____	Vomiting
____	____	Vomiting Blood

MUSCLE JOINT

YES	NO	(pain,numbness/weakness in)
____	____	Arms
____	____	Back
____	____	Feet
____	____	Hands
____	____	Hips
____	____	Legs
____	____	Neck
____	____	Shoulder

GENITO-URINARY

YES	NO	
____	____	Blood in Urine
____	____	Frequent Urination
____	____	Lack of Bladder Control
____	____	Painful Urination

SKIN

YES	NO	
____	____	Bruise easily
____	____	Hives
____	____	Itching
____	____	Rash
____	____	Scars
____	____	Change in mole
____	____	Non-healing scar

CARDIOVASCULAR

YES	NO	
____	____	Chest pain
____	____	Irregular Heartbeat
____	____	Low Blood Pressure
____	____	Poor Circulation
____	____	Rapid Heartbeat
____	____	Ankle Swelling
____	____	Varicose Veins

EYE/EAR/NOSE/THROAT

YES	NO	
____	____	Bleeding gums
____	____	Hoarseness
____	____	Nosebleeds
____	____	Persistent cough
____	____	Ringing in ears

FOR WOMEN ONLY

YES	NO	
____	____	Abnormal pap smear - Date of last papsmear_____
____	____	Bleeding between periods - Date of last period_____
____	____	Hot flashes Number of children _____
____	____	Had a mammogram
____	____	Pregnant

The following information will not be released and will only be used only for the purpose of our office.
Please circle conditions you have or had:

AIDS/HIV Positive **Alcoholism** **Chemical dependency** **Psychiatric Care**

Patient's Signature:_____ Date:_____

Physician's Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____Date of Birth:_____ SSN:_____

This notice advises you about the ways in which we may use and disclose your Protected Health Information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that relates to your past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to your PHI. The law requires us to provide a copy of this notice to you which explains our legal duties and privacy practices.

My signature acknowledges that I have been offered a copy of Chicago Hand & Orthopedic Surgery Centers Notice of Privacy Practices at the time of registration.

Signature:_____ Date:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any and all records of my treatment to be forwarded to the following: (Please check all that apply)

( ) The referring occupational clinic, my employer, workers compensation representative who will be handling my claim, as well as any physicians and ancillary personnel involved in my medical care.
( ) The referring physician and any physicians and ancillary personnel involved in my medical care.
( ) My primary care physician.
( ) My private health insurance carrier and any associated entities.
( ) My employer: _____
Name of employer

Signature:_____Date:_____

PHONE MESSAGE AND CONTACT AUTHORIZATION

At what phone numbers can we, or our representatives, call to speak with you and or leave a message regarding appointments or any other details related to your account? (Please circle Yes or No for each option)

Home Phone: YES NO Work Phone: YES NO Cell Phone: YES NO

Would you like to allow someone, other than yourself, to receive information regarding your treatment, appointments and billing/financial status at Chicago Hand & Orthopedic Surgery Centers? (Circle One) YES NO

If yes, please list their names, relationship and phone number below:

Name:_____Relationship_____Phone#:_____

Name:_____Relationship_____Phone#:_____

Name:_____Relationship_____Phone#:_____

Signature:_____Date:_____

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IMPORTANT INSURANCE/PAYMENT INFORMATION

Patient with private healthcare insurance:
The private healthcare insurance presented at the time of your visit will be billed for your treatment, HMO patients will need to start the process of securing a referral. Every effort will be made to ensure that claims are promptly and correctly submitted to your insurance company. Your insurance company has 30 days after receiving a correctly filed claim to process, pay, and/or give notice as to why claim has not been paid. After that time the remaining balance will be your responsibility. If you are not satisfied with the payment made by your insurance company, contact them directly at the phone number listed on your insurance card. If you choose to appeal to your insurance company in writing for additional payment, please provide Chicago Hand & Orthopedic Surgery Centers with a copy of that appeal for your file.

Patients with motor vehicle insurance/liability insurance:
If your injury was received as a result of a motor vehicle accident or a liability, and you do have private healthcare insurance, typically your private healthcare insurance will not make payments on your medical claims without a written denial from your motor vehicle insurance/liability insurance. It is very important that all pertinent information be given at the time of your visit regarding the motor vehicle insurance/liability insurance, including claim number, agent information, claim billing address, accident report etc.

Patients without private healthcare insurance – Self Pay:
If no private healthcare insurance is presented at the time of your visit, full payment or an approved payment plan is expected at the time of service.

Patients with Illinois Department of Public Aid – IDPA:
IDPA is not accepted at Chicago Hand and Orthopedic Surgery Centers. Full payment or an approved payment plan is expected at the time of service.

FOR ALL PATIENTS
*Any insurance policy is a contract between you and your insurance company.
*It is your responsibility to verify, with your insurance company, if a provider is in or out of network for your plan.
*Any unpaid balance left by your insurance company will be your responsibility.
*Insurance benefits paid directly to the patient will need to be forwarded to Chicago Hand & Orthopedic Surgery Centers to keep the account in good standing.
*If you have retained an attorney regarding your injury, it is very important to provide Chicago Hand & Orthopedic Surgery Centers with that information.
*Payment plans can be established with the approval of the billing department.
*Cash, checks, and all major credit cards are accepted for payment.
*You can contact the billing department with any questions.

Credit card payment authorization:
I hereby authorize Chicago Hand and Orthopedic Surgery Centers to use my credit card for co-pays, co-insurance, non-covered services, or other balances that are my financial responsibility if not paid within 45 days of service.

Credit card type:_____ Credit card account #:_____ ID #:_____ Expiration:_____

By signing below, the patient acknowledges that they have read the above information, understands this information and that upon request may obtain a copy of this form.

_____ _____ _____
Printed Name Signature Date