CHICAGO HAND & ORTHOPEDIC SURGERY CENTERS

PATIENT INFORMATION SHEET

Patient Name: _____ **DOB:** _____

Address: _____ SSN: _____
ADDRESS CITY, STATE, ZIP

Mailing Address: _____ ☐ Same as above
ADDRESS CITY, STATE, ZIP

Home phone: _____ Cell phone: _____ Work phone: _____

Marital Status: Single / Married / Widowed / Divorced Gender: F / M **E-mail address**: _____

Primary Care Physician: _____ City: _____ Phone Number: _____

Referring Provider: _____ City: _____ Phone Number: _____

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

Preferred method of communication: ☐ Home number ☐ Cell number ☐ Email ☐ Other: _____

Emergency contact: _____ Relationship: _____
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

Ethnicity: _____ Race: _____ Preferred Language: _____

Name of Employer: _____ Address: _____ Phone Number: _____

Insurance Information

Name of Primary Insurance: _____ ID #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to Patient: _____ DOB:_____ SSN#: _____

Name of Secondary Insurance: _____ ID #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to Patient: _____ DOB:_____ SSN#: _____

Guarantor Information **(FILL OUT THIS SECTION ONLY IF PATIENT IS A MINOR)**

Primary Guarantor/Parent/Guardian Name:_____ **DOB:** _____

Address: _____ **SSN:** _____
ADDRESS CITY, STATE, ZIP

Do you have an advanced directive such as a living will or medical power of attorney? ☐ Yes ☐ No

Preferred Pharmacy

Name: _____ Address: _____Phone Number: _____

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*

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 I may 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 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. An authorized, approved payment plan will eliminate collection fees. 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:* _____

*Private Insurance Policy Holder's Signature:*_____ *Date:* _____

CHICAGO HAND & ORTHOPEDIC SURGERY CENTERS

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)	YES	NO	
____	____	Asthma / Bronchitis	____	____	Stomach Ulcer / GERD
____	____	Emphysema	____	____	Liver Problem _____
____	____	Respiratory Disease	____	____	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	____	____	Other_____

FAMILY HISTORY

____	____	Family History of Anesthesia Problems (Mother / Father)	____	____	Family History of Diabetes (Mother / Father)
____	____	Family History of Bleeding Problems (Mother / Father)	____	____	Family History of Heart Disease (Mother / Father)

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: _____

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:_____

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.

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

CHICAGO HAND & ORTHOPEDIC SURGERY CENTERS

PROTECTED PRIVATE HEALTH INFORMATION

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

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

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

*Print Your Name:*_____

*Patient's Name: (Please print):*_____