BIRMINGHAM HAND & PLASTIC SURGERY

PATIENT INFORMATION QUESTIONNAIRE

Patient Full Name: _____ Date of Birth: _____

Social Security# _____ Height: _____ Weight: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Marital Status: _____

Home Phone # (_____) _____ Cell# (_____) _____ Work# (_____) _____

E-Mail Address: _____

Employer's Name: _____ Position Held: _____

In Case of Emergency Notify: Name: _____ (Relationship) _____

Phone# (_____) _____ Cell phone# (_____) _____

INSURANCE INFORMATION:

Insurance Name: _____ Policy# _____ Group# _____

Insured's Name: _____ Date of Birth: _____

Relationship to the patient: _____

Insurance Name: _____ Policy# _____ Group# _____

Insured's Name: _____ Date of Birth: _____

Relationship to the patient: _____

IF THE PATIENT IS A MINOR:
(PERSON RESPONSIBLE FOR BILL PAYMENT)

Name: _____ Date of Birth: _____ SSN# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone# (_____) _____ Cell# (_____) _____ Relationship to Patient: _____

Is this visit related to:

Job Injury Auto Accident Other Injury Date of Injury/Accident: _____

Primary Care Doctor/Family Physician: _____ Phone# (_____) _____

I was referred by: _____ Phone# (_____) _____

Reason for office consult/visit: _____

DRUG/FOOD ALLERGIES: _____

Do you use Blood thinners such as Coumadin, Plavix, Aspirin, etc. _____

Do you have Sleep Apnea: Y N Do you use C-Pap Machine: Y N

BIRMINGHAM HAND & PLASTIC SURGERY

PATIENT HISTORY SHEET

PATIENT'S NAME: _____ **Today's Date:** _____

REFERRED BY _____ **Reason for office visit:** _____

MEDICAL PROBLEMS: _____

_____

PAST SURGERIES: _____

_____

ALCOHOL CONSUMPTION: ( ) yes ( ) no Whiskey Beer Wine Other: _____ Weekly amount: _____

CAFFEINE CONSUMPTION: ( ) yes ( ) no Daily amount: _____

DO YOU SMOKE? ( ) yes ( ) no Date you quit: _____ Packs/Day: _____ Years smoking: _____

DRUG or FOOD ALLERGIES: _____

ARE YOU RIGHT OR LEFT HANDED: Right Left

DATE OF LAST EKG or STRESS TEST: _____ **Ordered by:** Dr._____

REVIEW OF SYSTEMS: Please circle all applicable answers:

H&N	Any trouble with nose, sinuses, mouth, throat	no	yes
CVR	Chest pain or shortness of breath	no	yes
	Night sweats,	no	yes
	Swelling of hands, feet or ankles	no	yes
	Rheumatic fever in the past	no	yes
	Tuberculosis or + PPD test	no	yes
	High or low blood pressure	no	yes
	Heart murmur	no	yes
	Heart attack	no	yes
	Emphysema	no	yes
	Clot in legs or lungs	no	yes
GI	Stomach ulcers	no	yes
	Cirrhosis of liver or Hepatitis	no	yes
GU	Kidney disease or Stones	no	yes
ENDO	Diabetes	no	yes
	Thyroid disease	no	yes
	Any diabetes in the family	no	yes
	(List) _____		
	Have you ever taken insulin for diabetes, or hormone shots or tablets?	no	yes
	If yes, please specify: _____		
B&J	Arthritis	no	yes
	Broken bones	no	yes
	If yes, please specify: _____		
HEMO	Anemia (Low Blood)	no	yes
	Do you bleed or bruise easily	no	yes
	Any unusual bleeding after surgery	no	yes
INTEG	Moles that have changed	no	yes
NEURO	Severe headaches, migraines	no	yes

PSYCHO-SOCIAL PROBLEMS:

Are you disabled? no yes

If yes, please explain reason_____

_____

Questions for female patients:

Are you, or might you be pregnant no yes

Have you had a hysterectomy no yes

if yes, when: _____

Do you use birth control pills, patches, ring or IUD no yes

specify:_____

FAMILY HISTORY

	If living		If deceased	
	Age	Health Status	Age	Cause
Father				
Mother				
Brothers				
Sisters				
Husband/Wife				
Sons				
Daughters				

List all medicines that you take now or have taken recently:

Currently taking:	Taken recently:

Please list any over the counter pills, vitamins, herbs, or dietary supplements: _____

_____

Birmingham Hand & Plastic Surgery

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Birmingham Hand & Plastic Surgery for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Birmingham Hand & Plastic Surgery. This protected health information may be used or disclosed to the Medical Association of the State of Alabama's Third Party Task Force to advocate on behalf of Birmingham Hand & Plastic Surgery and myself in the resolution of payment/reimbursement issues with _____and/or its affiliated entities.
(Insurance Name)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Birmingham Hand & Plastic Surgery is not required to agree to the restrictions that I may request. However, if Birmingham Hand & Plastic Surgery agrees to a restriction that I request, the restriction is binding on Birmingham Hand & Plastic Surgery.

I have the right to revoke this consent in writing, at any time, except to the extent that Birmingham Hand & Plastic Surgery has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health, or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have to review Birmingham Hand & Plastic Surgery. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Birmingham Hand & Plastic Surgery. This Notice of Privacy Practices also describes my rights and Birmingham Hand & Plastic Surgery duties with respect to my protected health information.

Birmingham Hand & Plastic Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature Date

MEDICARE PART B EXTENDED PATIENT SIGNATURE AUTHORIZATION	
STATEMENT FOR PAYMENT OF MEDICARE BENEFITS	***I request that payment of authorized Medicare benefits be made either to me or on my behalf to* Birmingham Hand & Plastic Surgery *for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.***
STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS	***I request that payment of authorized MEDIGAP benefits be made to me or on my behalf to* Birmingham Hand & Plastic Surgery *for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to be release to (name of MEDIGAP insurer) _____ any information needed to determine these benefits or the benefits payable for related services.***
	_____ _____ Signature of Medicare Beneficiary or person signing for Beneficiary Date
	_____ _____ Address of Person Signing for Beneficiary (Street, City, State, ZIP) Relationship to Beneficiary
	_____ Reason Beneficiary is Unable To Sign

I UNDERSTAND THAT:

A) This office files my insurance as a courtesy, but I am held responsible for any charges I incur.
B) My insurance company may not cover Birmingham Hand & Plastic Surgery charges in full, and I will be held financially responsible for the services I received.
C) I have the right the review the Office Billing Policy.
D) I acknowledge that Birmingham Hand & Plastic Surgery will only bill for two (2) insurances.
E) I acknowledge that Birmingham Hand & Plastic Surgery does not bill 3rd parties.

Financial Responsibility Policy: In the event the account is not paid in full within 60 days after the mailing of the first patient statement the account will be deemed in default and may be sent to a Collection Agency. A Collection Fee equal to 20% of the unpaid account balance will be assessed.

- I understand that certain rendered services may not be covered by my individual contract and I accept full financial responsibility for the immediate payment of any charges not covered by my insurance contract.
- If my insurance contract requires a specific referral or authorization from my Primary Care Physician and I have not obtained the required referral or authorization. I acknowledge and agree that any services rendered will be considered a self-referral for which I (or my Responsible party) shall be solely liable for payment.
- I agree that if my account is forwarded to a Collection Agency, I will be responsible for paying a Collection Fee equal to 20% of the outstanding balance, in addition to the unpaid account balance. Should it be necessary Attorney's Fees and/or court costs will be added to the unpaid account balance and Collection Fee.
- I hereby waive all rights of exemption under the U.S. and Alabama Constitutions and the laws of the State of Alabama.

Patient Consent for Use of Credit Cards and Debit Cards.

It may become necessary to release your protected health information to credit card entities, and banks, when requested, to facilitate your payment.

Services rendered and paid with a credit card or debit card are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Birmingham Hand & Plastic Surgery to used and disclose my protected health information to any Credit Card Entity or Bank when they request such information to process an account and assist with payment. I will not challenge such, credit, debit card payments once the services are provided.

By signing below I authorized/consent:

a) This office to release medical information to authorized persons such as doctors, insurance companies, or attorneys as the case may be.
b) The direct payment to Birmingham Hand & Plastic Surgery from the insurance company on record, and that any unpaid balance will be paid by me. I authorized to be contacted by telephone at any telephone number including wireless phone numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or used of automatic dialing device in order to service my account or to collect money I may owe to Birmingham Hand & Plastic Surgery.
c) To be photographed provided my identity is not revealed in the photo or text and the photos to be used for medical purposes only.

General Consent to Treat: I authorize Birmingham Hand & Plastic Surgery and their staff to conduct any diagnostic, examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that is the responsibility of my individual treating provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my treating provider. I also understand that the practice of medicine if not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent/Legal Guardian/Spouse, Other Date