HEALTHCARE REGULATIONS REQUIRE FORM TO BE FILLED OUT COMPLETELY

Welcome to Our Office

Today's Date: _____

_____ Sex: M_____F____

Last Name **First Name** **Date of Birth** **Age**

_____ _____

Mailing Address **City and State** **Zip** **Social Security Number (optional)**

Marital Status: S M W D Phone Numbers: Home( )_____**Cell(**)_____

E-mail _____

_____

Referring Physician

_____

Primary/Family Physician

_____

Primary Insurance **Subscriber's Name** **Date of Birth**

_____

Secondary Insurance **Subscriber's Name** **Date of Birth**

_____

Patient's Employer (indicate if student or retired) **Occupation** (circle one: Full or Part Time) Work Phone # and Ext

_____

Employer's Address City and State Zip Code

_____

If Minor, Parent/Guardian Name Social Security Number (optional)

_____

Parent/Guardian Address City and State Zip Code Home Phone Number

Is This a Worker's Compensation Case?
○ Yes ○ No ○ Potential
If yes, then patient must provide our office with written authorization.

Is This a No-fault Claim? (motor vehicle accident)
○ Yes, State where accident occurred_____
○ No ○ Potential
If yes, then patient must provide our office with written authorization.

Is This A Legal/Third Party Liability Case?
○ Yes ○ No ○ Potential
If yes, then patient will be responsible for payment.

Date of Injury: _____

Reason for visit today? (Example: shoulder, elbow, wrist, etc.)

_____

Please describe this problem and how it happened:

_____

_____

_____

_____

Are you: Right handed Left handed

GREAT LAKES HAND SURGERY CENTER

The information below will assist us in your care and in any communications with you, while protecting your confidentiality. Please review, circle your choices, and fill in any necessary information. You may amend this statement at any time.

YES NO Leave message regarding appointment and/or medical information on my machine and/or voicemail at:
Home Cell Work

YES NO May speak with _____ regarding my medical treatment. (please specify name)

YES NO May speak and/or fax information to my employer regarding my medical treatment.
Employer_____ Fax # _____

Contact Person To Notify In Case Of Emergency (List relatives or friends)

1. Name: _____
   Relationship to you:_____His/Her Phone #:_____

2. Name: _____
   Relationship to you:_____His/Her Phone #_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Great Lakes Hand Surgery Center may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Great Lakes Hand Surgery Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Great Lakes Hand Surgery Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Great Lakes Hand Surgery Center Privacy Officer at 3945 Okemos Rd, Suite B4, Okemos, MI 48864.

With my consent, Great Lakes Hand Surgery Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, cards, and patient statements.

I have the right to request that Great Lakes Hand Surgery Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Great Lakes Hand Surgery Center's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures to reliance upon my prior consent. If I do not sign this consent, Great Lakes Hand Surgery Center may decline to provide treatment to me.

In the event that my account becomes delinquent and a collection agency becomes involved, I understand that I will be financially responsible for all costs associated with collection of the delinquent balance.

I understand that I am financially responsible to pay any deductible and/or co-pay. I understand that I am responsible to pay a $25 broken appointment charge if I fail to cancel said appointment 24 hours in advance. I understand, if I do not have health insurance or have any uncovered benefits, I am financially responsible for the entire balance for all medical and surgical care rendered.

I understand that if I do not make payment upon receipt of my first statement, I will incur a *$10.00 per month* service fee for each additional statement sent.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

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