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[Label]

DEMOGRAPHICS

Patient LAST Name:		Patient FIRST Name:	M I:
Date of Birth:	Age:	M/F EMAIL	
Address:			
City:	State:	Zip:	SS#:
Day Phone: ( ) ☐ ok to leave msg		☐ single ☐ married ☐ Divorced/Separated ☐ Dependent	
Home Phone: ( ) ☐ ok to leave msg		Parent/Spouse Name:	
Are you Right or Left Handed?		Referring Provider:	
		Primary Care Provider:	

[With our recent mandated conversion to electronic medical record, we are now required to survey the following patient demographics.]

What language do you speak? _____

Race:
- ☐ American Indian or Alaska
- ☐ Asian
- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other/Undetermined

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

BILLING INFORMATION

Name of Person Responsible for Bill:			
Address *(if not above)*:		City:	State:
Zip:	Primary Phone: ( )	Other Phone: ( )	
Is this a work related injury? *(required)*	If yes, did you file a Workers Comp Claim?	Claim #:	
Name and Address of self-insured company:		Date of Injury:	
		Phone: ( )	

PRIMARY INSURANCE:		**OTHER INSURANCE:**	
Ins. Co. Name:		Ins. Co. Name:	
Subscriber Name:		Subscriber Name:	
Date of Birth:		Date of Birth:	
ID #:	Grp #:	ID #:	Grp #:
Subscriber's Employer:		Subscriber's Employer:	

Does your insurance carrier require a referral?: (If yes, it is your responsibility to obtain a referral from your primary care provider.)

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me by any of the physicians at Proliance Surgeons. I authorize any holder of medical information about me to release to HCFA and its agents or to my other insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment and I accept financial responsibility for non-covered services.

***SIGNATURE**: _____ **DATE:** _____

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Financial Policy

Proliance Hand, Wrist & Elbow Physicians, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Our credit and collection policy is in place to retain financial resources and maintain excellent health care for our patients and community.

Patient Responsibilities:

You help ensure an efficient experience by assisting with the following:

- Providing us with your photo identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations and ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Paying your portion of the charges and any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least a 24-hour advanced notice should you need to cancel or reschedule an appointment. We may charge a fee for missed appointments that is not covered by insurance.

Insured Patients:

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

- **Co-Pays/Deductibles/Co-Insurance** – Copays are due at the time of service. Co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.
- **Surgery** – If surgery is indicated, a pre-payment to the utilized surgery center may be required for facility fees for elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.
- **Non-Participating Insurance** – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Private-Pay/Uninsured Patients:

Office/Provider's Fees: – When visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office procedures (e.g., casting, scopes, tests, x-rays) will be billed separately from the office visit. Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office. Any private payments made will be refunded once all visits have been processed by insurance.

*Exclusions: The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Workers' Compensation Patients:

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier.

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Financial Policy – cont.

Motor Vehicle Accidents (MVA) Insured and Third Party Patients:
We will need the claim number, carrier name and claim manager contact information prior to your visit in order to bill the MVA/Third Party insurance carrier. We will bill the insurance carrier one time. The bill becomes your responsibility if not paid by the carrier within 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished with the necessary information for the date of service.

Payment:

- **Payment Options** – We accept checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.
- **Delinquent Accounts** – We charge 5% interest accruing monthly on balances over 45 days old. We may assign an account to collections if balances are unpaid after 120 days. Patients assigned to collections may be denied additional service.
- **Alternative Payment Arrangements** – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.
- **Bankruptcy/Prior Bad Debt/Collections** – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Proliance Hand, Wrist & Elbow Physicians or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service in addition to any outstanding collection balances.

Short Form Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. We will not disclose your record to others without your signed consent or the law authorizes us to do so. You may ask to see, copy, or correct your records. To get more information about your records, call our office and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. You may request a copy of our complete Notice of Privacy Practices at any time.

By my signature below I acknowledge that I have read and accept the Financial Policy and the Short Form Notice of Privacy Practices and I am aware that the complete Notice of Privacy Practices is available to me at my request.

_____ _____
Patient or legally authorized individual signature | Date

_____ _____
Printed name if signed on behalf of the patient (Parent, legal guardian, Personal Representative) | Relationship

This form will be retained in your medical record.

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Patient Health History Form

Phone: (425) 823-4224 Fax: (425) 820-8975

[Label]

DEMOGRAPHICS:

Patient Name: _____

Date of Birth: _____

Male: ☐ Female: ☐ (Pregnant: No ☐ Yes ☐ Unsure ☐)

Height: _____ Weight: _____

Age: _____

Office Use: BP: _____ HR: _____

Referring Physician: _____

Primary Care Physician: _____

What are you being seen for today? _____

Are you Right or Left Handed? _____

ALLERGIES

☐ I have no allergies to medication.

Medication	Reaction	Medication	Reaction
1)		4)	
2)		5)	
3)		6)	

Latex allergy? ☐ No ☐ Yes

Food allergy? ☐ No ☐ Yes, type _____

Please list below any pain medications you do not tolerate.

_____

MEDICATIONS

Please list ALL medications and doses that you are CURRENTLY taking (this includes birth control pills, hormones, IUDs, vitamins and herbal supplements):

Medication	Dose/ Strength	# Pills per Day	Reason
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Have you ever had history of anemia or blood disorder? ☐ No ☐ Yes, explain _____

Have you or any relatives had problems with anesthesia? ☐ No ☐ Yes, explain _____

Have you ever had an EKG? ☐ No ☐ Yes, when/ where? _____

Do you get shortness of breath when climbing more than 2 flights of stairs? ☐ No ☐ Yes

Have you ever had a MRSA infection? ▾ If Yes, explain: _____

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Patient Health History Form- Page 2

PAST SURGICAL HISTORY

Please list the surgical procedures you have undergone:

Date of Surgery	Type of Surgery	Describe the Recovery
1)		
2)		
3)		
4)		
5)		
6)		
7)		

PAST MEDICAL HISTORY

	Explain		Explain
☐ Anemia		☐ Kidney/ bladder infections	
☐ Arthritis (“wear and tear”)		☐ Kidney stones	
☐ Asthma		☐ Kidney problems, other	
☐ Bleeding problems		☐ Liver problems	
☐ Blood clots		☐ Lupus	
☐ Cancer		☐ MRSA	
☐ COPD/ Emphysema		☐ Osteoporosis or osteopenia	
☐ Depression		☐ Prostate problems	
☐ Diabetes		☐ Psychiatric problems	
☐ Drug or alcohol problems		☐ Rheumatoid arthritis	
☐ GERD / reflux		☐ Scoliosis	
☐ Gout		☐ Seizures	
☐ Hearing problems		☐ Stroke	
☐ Heart attack		☐ Thyroid problems	
☐ Heart disease		☐ Tuberculosis	
☐ Hepatitis		☐ Ulcerative colitis/ Crohn’s	
☐ High blood pressure		☐ Ulcers	
☐ HIV positive/ AIDS		☐ Other:	

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Patient Health History Form- Page 3

FAMILY HISTORY: *Please check any conditions associated with your immediate family members*

	Mother	Father	Son	Daughter	Brother	Sister	Other
Anesthesia Problems	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐	☐	☐	☐
Cancer: _____	☐	☐	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐	☐	☐
COPD/Emphysema	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐	☐	☐
Alcohol Addiction	☐	☐	☐	☐	☐	☐	☐

	Mother	Father	Son	Daughter	Brother	Sister	Other
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure/Hypertension	☐	☐	☐	☐	☐	☐	☐
Malignant Hyperthermia	☐	☐	☐	☐	☐	☐	☐
Osteoporosis / Osteopenia	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Do you use tobacco products?

☐ Yes, I smoke_____packs per day

☐ Yes, I currently chew tobacco/ snuff

☐ No, I quit smoking/ chewing _____years_____months ago

☐ No, I have never used tobacco products

Current situation?

☐ Married ☐ Divorced

☐ Single ☐ Widowed

☐ Separated

☐ Living with significant other

Do you consume alcoholic beverages (e.g., beer, wine, liquor)?

☐ No ☐ Yes, type: _____ amount/ week: _____

Do you use illicit drugs? ☐ No ☐ Yes, type: _____

Do you have children?

☐ No ☐ Yes, how many? _____

Do you live: ☐ alone ☐ with spouse, family, and/ or friend(s) ☐ assisted living

Have you had a recent change in a significant relationship in the last year or other stress? ☐ No ☐ Yes

If yes, please explain: _____

WORK HISTORY

What is your occupation or previous one if currently not working? _____

Briefly describe your job: _____

Name of employer: _____ **Last date worked:** _____

Please mark ONE statement that best describes your current employment situation:

☐ currently working

☐ on paid leave

☐ on unpaid leave

☐ unemployed

☐ student

☐ homemaker

☐ disabled/ retired from an orthopedic and/or spine problem

☐ disabled/ retired from a health problem (NOT from an orthopedic or spine problem)

☐ retired (not due to health)

☐ other, please specify_____

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Patient Health History Form- Page 4

REVIEW OF SYSTEMS

Please mark the circle next to ANY symptoms you have experienced in the past 6 months:

Constitution	Eyes	Gastrointestinal	Other
☐ Fever	☐ Blurred Vision	☐ Heartburn	☐ Easy Bruise/Bleed
☐ Chills	☐ Double Vision	☐ Nausea	☐ Environmental Allergies
☐ Weight Loss	☐ Sensitivity to Light	☐ Vomiting	☐ Other _____
☐ Malaise/Fatigue	☐ Eye Pain	☐ Abdominal Pain	**Neurological**
☐ Sweating	☐ Eye Discharge	☐ Diarrhea	☐ Dizziness
☐ Weakness	☐ Eye Redness	☐ Constipation	☐ Headaches
☐ Other _____	☐ Other _____	☐ Blood in Stool	☐ Tingling
Skin	**Cardiovascular**	☐ Melena	☐ Tremor
☐ Rash	☐ Chest Pain	☐ Other _____	☐ Sensory Change
☐ Itching	☐ Palpitations	**Genitourinary**	☐ Speech Change
☐ Other _____	☐ Shortness of Breath	☐ Painful Urination	☐ Focal Weakness
HENT	☐ Leg Cramps	☐ Urgency of Urination	☐ Seizures
☐ Hearing Loss	☐ Leg Swelling	☐ Frequency of Urination	☐ Loss of Consciousness
☐ Ringing in Ears	☐ Sleep Apnea	☐ Blood in Urine	☐ Other _____
☐ Ear Pain	☐ Other _____	☐ Flank Pain	**Mental Health**
☐ Ear Discharge	**Respiratory**	☐ Other _____	☐ Depression
☐ Nosebleeds	☐ Coughs	**Musculoskeletal**	☐ Suicidal Ideas
☐ Congestion	☐ Coughing up Blood	☐ Muscle Pain	☐ Substance Abuse
☐ Sinus Pain	☐ Sputum Production	☐ Neck Pain	☐ Hallucinations
☐ Stridor	☐ Shortness of Breath	☐ Back Pain	☐ Nervous/Anxious
☐ Sore Throat	☐ Wheezing	☐ Joint Pain	☐ Insomnia
☐ Excessive Thirst	☐ Other _____	☐ Falls	☐ Memory Loss
☐ Other _____		☐ Other _____	☐ Other _____

☐ **I have not had ANY of the above symptoms in the last 6 months.**

SIGNATURE

Patient's signature: _____ Date: _____

Please print name: _____

Physician's signature: _____ Date: _____

Please print name: _____

(For Future Use)
Updated: Initials: _____ Date: _____

Initials: _____ Date: _____ Initials: _____ Date: _____