Name:

Chart:

Date:

Provider:

Patient Information Sheet

Patient Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____

1) Preferred pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

2) Preferred language: _____

3) In which of the following categories would you place yourself?

☐ American Indian ☐ Native Hawaiian ☐ Asian ☐ Caucasian

☐ African American ☐ Unknown ☐ Decline

4) In which of the following categories would you place yourself?

☐ Hispanic or Latino ☐ Decline ☐ Non-Hispanic or Latino

5) How would you best describe your smoking status?

☐ Never a Smoker

☐ Current Every Day Smoker

☐ Former Start date: _____ End Date: _____

6) Please list any medications you are ALLERGIC to: ☐ **None**

Medication	**Reaction**	**Severity** (Mild, Moderate, Severe, or Unknown)

7) What is it that you are being seen for today (Chief Complaint)? _____

8) Have you been treated by another physician for this problem?

☐ No ☐ Yes If Yes, who: _____ When: _____

9) Please list ALL previous TESTING you have received for this problem:

☐ X-Rays	Date: _____	☐ Arthogram	Date: _____
☐ Nerve Studies (**EMG/NCS**)	Date: _____	☐ Surgery	Date: _____
☐ Neurology Consult	Date: _____	☐ Prescribed Anti-Inflamatory Medications	Date: _____
☐ MRI	Date: _____	☐ Steroid Injection(s)	Date: _____
☐ CT Scan	Date: _____	☐ Splints/Braces	Date: _____
☐ PET Scan	Date: _____	☐ Other	Date: _____
☐ Bone Scan	Date: _____	☐ **NO PREVIOUS TREATMENT/TESTING**	Date: _____

Name:
Chart:
Date:

Indiana Hand to Shoulder Center

PRIVACY NOTICE ACKNOWLEDGEMENT

By signing below, I acknowledge that I have reviewed the Indiana Hand to Shoulder Center's notice of Privacy Practices. I also agree that the Indiana Hand to Shoulder Center may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. INTL _____

FMLA AND DISABILITY FORMS

MediCopy will complete all FMLA and Disablity Forms for our office. There is a $30 fee for the first form and a $15 for each additional form turned in at the same time. A Release of Information Form MUST be completed by each patient before paperwork is accepted. Patients must provide the company mailing address and/or fax number in which to return completed forms. Originals will not be returned to patient. We will determine your restrictions; your disability company will determine disbursement of any disability payments. INTL _____

FINANCIAL RESPONSIBILITY

The services provided by Hand Surgery Associates of Indiana are billed separately. Because insurance carriers recognize Hand Surgery Associates of Indiana as a physician treatment facility, separate billing is necessary. The following entities will each be billed separately and all insurance related services (claim filing, co-pay and deductible collection) will be handled separately:

- Physician Clinic Services (Hand Surgery Associates of Indiana) and Therapy Services (The Hand Rehabilitation Center of Indiana)
- Surgery Facility (Ambulatory Surgery Center) - Beltway Surgery Center

A patient may at any time ask a health care provider for an estimate of the price the health care providers and facilities will charge for providing a nonemergency medical service. The law requires that the estimate be provided within 5 business days.

Insurance Authorization Agreement:

I hereby assign Hand Surgery Associates of Indiana compensation carriers, employers, guardians and Medicare or Medicaid, information concerning my illness and treatments and I hereby assign to the practice all payments received for medical services rendered to myself or my dependents. INTL _____

Financial Responsibility:

I am responsible for all financial obligations of health services and for the reimbursement of any payment of claims from my insurance company. I understand that I am responsible for verifying my insurance is in network and for any amount not covered by insurance. If this account is in default and is referred to a third party for collection, the undersigned Guarantor agrees to pay provider, reasonable attorney's fees, and other monies allowable by law. INTL _____

*I understand I may be charged $50 for any missed appointment. INTL_____

If you have provided your cell phone as a valid means of contact, we may need to reach you at this number to discuss your account. **Please read the below statement and choose option 1 or 2 below:**

My cell phone may be used for the purpose of discussing my account. This includes the use of auto-dialed calls.

☐ **I Agree** ☐ **I Disagree; do not use my cell phone for the purpose of discussing my account.**

DISCLOSURE OF INFORMATION

I hereby request Indiana Hand to Shoulder Center to make the use or disclosure of my Protected Health Information to the following person(s):

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Signature (Parent / Guardian if patient is a minor) Date

*Indiana Hand to Shoulder Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Name:
DOB:

HISTORY & PHYSICAL

Chief Complaint: _____ Height: _____ Weight: _____ BMI: _____

ALLERGIES (Please list)

Latex Allergies: ☐ No ☐ Yes _____

Drug/Food/Environmental Allergies: ☐ No ☐ Yes

PAST MEDICAL HISTORY (Check all that apply) ☐ None

☐ Infections (list) ☐ MRSA ☐ TB ☐ VRE ☐ Other
☐ Heart Disease ☐ Defibrillator ☐ Murmur ☐ Pacemaker
☐ High blood pressure ☐ Stroke
☐ Lung Disease / Asthma / COPD ☐ Diabetes
☐ Bleeding / Blood Thinners ☐ Seizures / Epilepsy
☐ Ulcers/Reflux ☐ Thyroid disease
☐ Liver Disease / Hepatitis
☐ Kidney Disease ☐ Transplant ☐ Dialysis
☐ Artificial joints
☐ Other (please explain) _____

PREVIOUS SURGERIES ☐ None **Year**

SOCIAL HISTORY ☐ None

Smoke ☐ Yes ☐ No _____ packs / day
Alcohol use ☐ Yes ☐ No _____ drinks / day
Drugs (recreational) ☐ No ☐ Yes

FAMILY HISTORY ☐ None

☐ Diabetes _____ ☐ Other
☐ Cancer _____
☐ Heart Disease _____
☐ Thyroid Please list relationship: _____

MEDICATIONS Dose/Staff Use

☐ None

(Attach, or list, additional meds on the back of this form)

REVIEW OF SYSTEMS

Please indicate if you currently have or are being treated for any of the below listed problems. Check any that apply today, or that that you have had in the past. If box is not checked then Review is negative.

CHEST
☐ Chest Pain
☐ Irregular heart beat
☐ Pacemaker
☐ Heart murmur

NEUROLOGICAL
☐ Fainting
☐ Frequent headaches
☐ Seizures
☐ Numbness/Tingling

INTEGUMENTARY
☐ Rash
☐ Bruise easily

MUSCULOSKELETAL
☐ Muscle pain
☐ Joint pain

LUNGS
☐ Wheezing
☐ Shortness of breath

PSYCHIATRIC
☐ Depression
☐ Anxiety
☐ Psychiatric problems

Have you ever had an adverse reaction to anesthesia?
☐ No ☐ Yes

Have you or a family member ever experienced high fever due to anesthesia (Malignant Hyperthermia)?
☐ No ☐ Yes

Do you currently have a pain contract with another physician?
☐ No ☐ Yes (list provider):

_____
Physician Signature Only Date

Indiana Hand to Shoulder Center

Treatment for Safe and Effective Controlled Substance Prescriptions

This Controlled Substance Medication Agreement is a tool to allow the physician and patient to work together in good faith, and for you, the patient, to understand the importance of these medications. A "controlled substance medication" is a drug or chemical that is highly regulated by the government because of the potential dangers they pose when not used as prescribed by a physician. If you cannot agree to the following terms, we will be unable to prescribe controlled pain medication. Failure to follow all terms will result in discontinuation of the pain medication and/or dismissal from the practice.

1. I know that controlled substances are one part of my treatment plan to help my condition and make quality of life better. I know that controlled substance will not cure my condition. I understand that if my function does not improve while taking these medications or if I develop rapid tolerance or loss of improvement, the medicine may be discontinued or the dose may be lowered.

2. I understand that in order to best treat my condition it will require me to commit to a healthy lifestyle including eating a healthy diet, staying as physically active as possible and managing my stress. I agree to work with my provider to achieve a healthy lifestyle. I also will actively participate in Return to Work efforts and in my program designed to improve function (defined as social, physical, psychological and daily work activities). I agree to participate in any recommended psychiatric or psychological counseling if necessary.

3. I know that my treatment may change as my provider evaluates my progress or more medical information is available. If my doctor feels I need to see a specialist I agree to get a consultation.

4. I will take my controlled substance medication only at the dose and frequency prescribed. I will not increase or change medications without the approval of this provider.

5. If I am an adult receiving a controlled substance for the first time from this provider or I am under the age of 18 I understand that the initial prescription will not exceed a 7 day supply.

6. I am responsible for my controlled substance medication. I will keep my prescriptions and medications in a secure area away from children and others. I understand that sharing, selling or trading my medication is illegal and is a felony. If the paper prescription and/or medication is lost, misplaced, stolen or if I used them up too soon, I know that the medication will not be replaced. I agree to bring in my medications for pill counts at the request of the provider.

7. I will not ask for or take controlled substance medication from another doctor or person. If I am given these medications by another physician or in time of emergency I will notify my provider the next business day.

8. Refills of controlled substance will only be given if I keep my scheduled appointment(s). I will call at least 3 business days ahead if I need a refill on the controlled substance medication(s) and know that refills will only be granted during regular business hours Monday through Friday.

9. I know that any controlled substance may interfere with or impair my ability to drive, perform intricate tasks and make important decisions. I understand that it is my responsibility to refrain from any activities that will endanger me or others while taking a controlled substance.

10. I will not use illegal drugs, including marijuana. I agree to give a sample whenever asked for drug testing to make sure I am safely using my medications. If other drugs are found in my urine that are not prescribed or illegal I understand that my provider will be unable to prescribe further controlled substance and that I may be referred for help with chemical dependency. In addition, if the medication I am prescribed is not present in the sample, my provider may decide to terminate this agreement.

11. If I change my pharmacy for any reason, I agree to tell my provider. By signing this agreement, I give full consent for this provider to talk with the pharmacist about my condition and prescription history.

12. For females of child bearing potential, I understand that taking controlled substance while pregnant is dangerous. Taking controlled substance during pregnancy can cause harm to fetus and can lead to severe neonatal withdrawal after birth. Sudden discontinuation without supervision can lead to fetal demise.

I have read and I understand this agreement:

Patient Signature: _____ Date: _____