RHODE ISLAND HAND & ORTHOPAEDIC CENTER
PATIENT INFORMATION SHEET

DATE: _____

NAME: _____DOB: ____/____/____ AGE: _____

M / F SSN:_____/_____/_____ADDRESS:_____

CITY:_____STATE:_____ ZIP_____

HOME PHONE: _____CELL:_____WORK:_____

EMPLOYER: _____

EMAIL: _____@_____ MARITAL STATUS: S M D W OTHER

PHARMACY NAME _____ PHONE:_____
ADDRESS:_____

WHO REFERRED YOU TO OUR OFFICE?_____

PRIMARY CARE DOCTOR: _____PHONE:_____

OFFICE ADDRESS: _____
If your insurance requires a referral number for this visit please be sure your primary care physician has called or faxed us a referral for today's visit.

HEALTH INSURANCE
PRIMARY: _____ID#_____GROUP_____

ADDRESS:_____

SUBSCRIBER NAME:_____DOB:___/___/___RELATIONSHIP_____

SECONDARY:_____ID:_____GROUP_____

ADDRESS:_____

IS THIS A WORKER'S COMP CLAIM: YES_____NO_____ DATE OF INJURY:_____

WCOMP INSURANCE CO:_____ADJUSTER:_____
INS. CO
ADDRESS:_____CITY_____STATE_____ZIP_____

PHONE:_____CLAIM#_____EMPLOYER:_____

EMP ADDRESS_____CITY_____STATE_____ZIP_____

PHONE:_____CONTACT PERSON:_____
IS THIS A LIABILITY? YES_____NO_____

NAME:_____ **DATE:**_____

AGE: _____ ***DOMINANT HAND*: RIGHT / LEFT *AFFECTED HAND:* RIGHT /LEFT**

JOB TITLE:
DESCRIBE YOUR TASKS AT WORK:

_____

_____

LIST YOUR HOBBIES AND INTERESTS:

_____

DESCRIBE YOUR HAND/ARM PROBLEM:

_____

_____

LIST ANY DIAGNOSTIC TESTS YOU HAVE HAD: _____

_____

WORK RELATED? YES NO **DATE OF ONSET INJURY:**_____

DESCRIBE ANY PREVIOUS HAND/ARM INJURY OR SURGERY:

_____

_____

MEDICAL PROBLEMS:

_____**HIGH BLOOD PRESSURE**	_____**OSTEOARTHRITIS** _____**GOUT** _____ **NONE**
_____**ANGINA/HEART ATTACK**	_____**RHEUMATOID ARTHRITIS** ____**ASTHMA**
_____**OVERACTIVE THYROID**	_____**DIABETES-INSULIN DEPENDENT? YES NO**
_____**UNDERACTIVE THYROID**	_____**CANCER – WHAT TYPE:** _____
_____**GASTRITIC/PEPTIC ULCER**	_____**OTHER – SPECIFY** _____
_____ **MRSA**	_____ **C DIFF**

PAST SURGERY: _____ **NONE**

_____

CURRENT MEDICATIONS: _____ **NONE**

_____

ALLERGIES: _____ **NONE**

_____

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY FOR THE RI HAND & ORTHOPAEDIC CENTER. I ALSO ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THAT I MIGHT HAVE ABOUT THIS NOTICE.

_____

PRINT NAME **DATE OF BIRTH**

_____

SIGNATURE **DATE**

_____

REPRESENTATIVE

_____

RELATIONSHIP

_____ UNDER AGE _____ POWER OF ATTORNEY _____ OTHER

I, _____, AUTHORIZE YOU TO RELEASE MEDICAL INFORMATION TO THE FOLLOWING:

_____

NAME **RELATIONSHIP**

_____

NAME **RELATIONSHIP**

_____

NAME **RELATIONSHIP**

_____

PATIENT SIGNATURE **DATE**

FINANCIAL AGREEMENT
INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE RHODE ISLAND HAND & ORTHOPAEDIC CENTER, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONERNING MY ILLNESS AND TREATMENT, AND HEREBY ASSIGN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE AND AFTER SIXTY (60) DAYS IF NO PAYMENT HAS BEEN RECEIVED BY THIS OFFICE, FULL PAYMENT IS DUE AND PAYABLE BY ME.

SIGNATURE_____**DATE**_____
(PATIENT OR PARENT IF MINOR)

MEDICARE PATIENTS MUST SIGN BELOW

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE WHETHER TO ME OR ON MY BEHALF TO RHODE ISLAND HAND & ORTHOPAEDIC CENTER, P.C. FOR ANY SERVICES FURNISHED TO ME BY LEONARD F. HUBBARD, M.D. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTER FOR MEDICARE AND MEDICAID SERVICES, FORMERLY HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE_____ **DATE**_____

MEDICARE#_____

FINANCIAL AND CANCELLATION POLICIES

CANCELLATION/NO SHOW POLICY

In order to ensure appointment times for each of our patients Rhode Island Hand & Orthopaedic Center requires a 24 hours NOTICE of cancellation for all scheduled doctor visits.

A $25.00 CANCELLATION fee will be assessed to appointments that are not canceled at least 24 HOURS prior to the scheduled time. This fee will be applied to each missed appointment and must be paid by the patient. (Your insurance will not cover this charge). This policy will allow us to accommodate all patients.

ADDITIONAL CHARGES:

Returned check fee: $15.00 per check

Physician Copayment: $10.00 if not paid at the time of service to cover billing costs

Copy of Medical Records: $15.00

Payment with credit cards: $3.00 service fee

Insurance Changes: If a patient does not alert the office of a change in insurance, any charges denied by the insurance company due to timely filing will be the patient's responsibility.

Delinquent Accounts: Any patient balance over 30 days will incur an annual finance charge of 18%

I am aware of my financial responsibility to Rhode Island Hand & Orthopaedic Center. I understand and agree to the above terms and conditions.

_____ _____

Patient Signature Date