Findling Surgical, P.C.

Fillip M. Findling D.O.

Surgery of the Hand, Wrist, & Elbow

PATIENT INFORMATION SHEET

Patient Information

Last Name:_____ First Name:_____ Gender:_____

DOB:_____/_____/_____ SS#_____-_____-_____ Marital Status:_____

Address:_____ City/State/Zip:_____

Phone Numbers: (please place ** next to preferred number)

Home:_____-_____-_____ Work:_____-_____-_____ Cell: ____-_____-_____ E-mail:_____

Emergency Contact Name:_____ Phone_____-_____-_____ Relationship:_____

Guarantor Information: (please complete if patient is under 18 years of age)

Last Name:_____ First Name_____ SS#_____-_____-_____

Address:_____ City/State/Zip:_____

DOB:_____/_____/_____

Phone Numbers: Home_____-_____-_____ Work:_____-_____-_____ Cell:_____-_____-_____

Insurance Information:

Primary Insurance Co._____ Policy #:_____ Group#:_____

Name of Insured:_____ Relation to Patient:_____

SS#:_____-_____-_____ DOB:____/____/_____ Address:_____

Employer Name: _____ Employer Address:_____

Work Status:_____ Occupation:_____ Phone:_____-_____-_____

Secondary Insurance Co._____ Policy #:_____ Group#:_____

Name of Insured:_____ Relation to Patient:_____

SS#:_____-_____-_____ DOB:____/____/_____ Address:_____

Employer Name: _____ Employer Address:_____

Work Status:_____ Occupation:_____ Phone:_____-_____-_____

CONSENT TO EVALUATE/TREAT:

I, for myself, or the patient named above, hereby consent to such medical evaluation and/or treatment and diagnostic procedures (e.g. x-rays, MRI, videotaping) as necessary and appropriate for my condition or illness based on the judgment of my physician(s), to be performed by the physician(s), physician assistant(s), nurse(s) or other health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my health care provider, ask questions regarding such treatment options and understand the options discussed.

I assume full responsibility for all items of personal property that I have brought to Findling Surgical, P.C. and release Findling Surgical, P.C. of all liability in the event of loss or damage to such property.

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Name of Authorized Representative: _____

Relationship of Authorized Representative: _____

Findling Surgical, P.C.

Name:_____Preferred Name/Nickname:_____ Age:_____

Date of Birth:_____ Dominant Hand (Circle): Right-handed Left-handed

Occupation:_____ Employer:_____ Primary Care Doctor:_____

Injured Side (Circle): Right Left Both Referring Provider: _____

What problem are you here to be treated for today?

_____

_____

Date of Injury or Duration of symptoms:_____(circle) days weeks months years

If this is an injury, explain how it happened:

_____

_____

Have you had any prior treatment (medication, splinting, therapy, injections, surgery, etc.) or any prior studies (X-rays, nerve tests, CT scan, MRI scan) related to this problem? Please list:

_____

_____

Is this injury work related? YES NO Do you have legal representation? YES NO

Name of Attorney:_____

List Allergies to Medications (and type of reaction if known):

_____

List all Medications You Are Taking (including over-the-counter medication, vitamins and supplements):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Medical History:
Please circle any of the following medical conditions that you are currently being treated for or have been treated for in the past:

Anemia	Drug Addiction	Liver Problems
Angina (Chest Pain)	Fibromyalgia	Lung Problems
Anxiety/Depression	GERD/ Reflux	Neck / Back Pain
Arthritis	Gout	Rheumatoid Arthritis
Asthma	Heart Attack	Scleroderma
Bleeding Disorders	Heart Murmur	Siezures
Blood Clots	Hepatitis	Skin Disorders
Bowel / Bladder Cancer	Hypertension	Stroke
Cholesterol	HIV/ AIDS	Thyroid Problems
Diabetes	Kidney Failure	Tuberculosis (TB)

Other Medical Conditions you have:_____

Other physicians who are treating you (include their specialty):

_____

List all operations you have had performed (if known, include year and surgeon name):

_____

_____

Family History:
Please circle any of the following problems which affect your family members (brothers/sisters, parents, grandparents, etc.):

Cancer Diabetes Bleeding Disorders High Blood Pressure Strokes

Arthritis Blood Clots Heart Problem Birth Defects Problems with Anesthesia

Other: _____

Social History:

Do you smoke?	YES	_____Packs Per Day	NO
Do you drink alcohol?	YES	_____Drinks per Day	NO
Have you abused drugs?	YES	_____drug/amount	NO
Are you pregnant or nursing?	YES		NO

Marital status (circle): Single Married Divorced Widowed Other _____

Review of Systems: Circle if you have ever had any of the following symptoms:

General: fever, weight loss, malaise, excessively tired, nausea
Eyes: double vision, blurred vision, trauma, visual changes
Ears, Nose, Throat: deafness, ringing in ears, hoarseness, dizziness, sinus problems
Heart, Vascular: chest pain, irregular heartbeat, shortness of breath, swelling of legs
Lungs: asthma, cough, coughing blood, difficulty breathing lying flat
Intestines: loss of appetite, diarrhea, constipation, abdominal pain, vomiting
Urinary: difficulty urinating, incontinence, painful urination
Skeletal: joint swelling, joint pain, arthritis, fracture, loss of motion
Skin: skin rash, facial rash, skin lesions, skin ulcers, warts, skin cancer
Neurologic: speech problems, numbness, weakness, loss of balance, loss of memory
Psychiatric: depression, hallucinations, sleep problems, mood swings, crying spells
Endocrine: increased thirst/appetite, hair changes, growth changes, hot/cold spells
Hematologic: anemia, bruising, excessive bleeding, hemophelia, blood transfusion
Allergic: trouble breathing after medication, swollen lymph nodes/glands

I certify that the information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the medical staff to perform any necessary medical services that I may need during diagnosis and treatment with my informed consent.

Patient's Signature: _____ Date: _____

Physician Signature: _____ Smoking cessation discussed

Findling Surgical, P.C. PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible health care. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility.

We participate with most insurance plans. Each plan has different benefits as well as financial obligations as chosen by your employer. **NOT ALL INSURANCE POLICIES COVER ALL SERVICES. It is YOUR RESPONSIBILITY** to check with your insurance company to determine your covered benefits.

The following are financial guidelines for Findling Surgical, P.C.:

Payment is expected at the time of service. (This includes co pays, coinsurance and deductibles.)

♦We will file your insurance as a courtesy. Please have a current copy of your insurance card with you for your visit. If a claim is not paid in a timely manner it is the patient's responsibility to contact the insurance company for follow up. If your insurance requires a referral it is **YOUR responsibility** to obtain it prior to your appointment. If you do not have it you will be required to reschedule.

♦New patients with no insurance will be required to pay a $100.00 payment prior to being seen by your physician. Outstanding patient balances on your account must be paid in full prior to receiving additional service.

♦Patients will be financially responsible for medical services related to accidents that are filed to a third party.

♦If you are a surgical patient, we require payment of a surgery deposit. This amount will be based upon the allowed charge amounts from your insurance company. This amount is to be paid **prior** to your surgery.

♦There is a charge to complete disability forms. Disability forms take 7-10 days to complete.

♦There is a $35.00 no show fee for any appointment missed that is not cancelled or rescheduled within 24 hours.

♦There is a $75.00 fee for any surgery that is cancelled or rescheduled more than 2 times.

There is a $35.00 service charge for the following:

- **Returned Check**
- **Co-payment not received within 24 hours of service.**
- **Re-filing of insurance due to incomplete or incorrect information given at the time of appointment**

We accept the following forms of payment: CASH, CHECK, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

Accounts may be turned over to a collection agency if past due 60 days or more. Should we deem it necessary to involve a third party in the collection effort, patients are responsible for all costs involved with the collection of their past due balance, including a collection fee equal to 30% of the unpaid balance, reasonable attorney fees and court costs where applicable, as well as any other expenses incidental to the collection of their delinquent account.

I have read and understand the above stated financial policy of Findling Surgical, P.C. I agree to honor the terms and conditions of this policy and understand that any failure on my part to do so will constitute default and may result in the use of any and all available legal means to cure this default.

Patient or Guardian Signature: _____ Date:_____

Witness:_____ Date:_____

Findling Surgical, P.C.

Notice of Privacy Practices

To our patients. This notice describes how health information about you, as a patient of Findling Surgical, P.C, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996
(HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Findling Surgical, P.C. 15 Munro Blvd, Valley Stream, NY 11581

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Findling Surgical, P.C. 15 Munro Blvd, Valley Stream, NY 11581. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact Findling Surgical, P.C. 15 Munro Blvd, Valley Stream, NY 11581.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services.
   To file a complaint with our practice, contact: Findling Surgical, P.C. 15 Munro Blvd, Valley Stream, NY 11581. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact

Findling Surgical, P.C. 15 Munro Blvd, Valley Stream, NY 11581. (516) 791-5800

This notice is effective as of December 1, 2013.

Source: *Advocacy Resource Center of the American Medical Association, October 1999*

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Findling Surgical, P.C.
Acknowledgement of Receipt of
Notice of Privacy Practices

Patients Name

I acknowledge that I have received a copy of Findling Surgical, P.C.'s Notice of Privacy Practices

Signature: _____

Date: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining the acknowledgement

_____Other (Please specify): _____

Signature: _____ Date: _____

Permission is granted to also release my medical information to:

Name Date of Birth
