Trinity Hand Specialists, PLLC

2335 Knob Creek Rd., Suite 100 ■ Johnson City, TN 37604 ■ Phone 423-282-5332 ■ Fax 423-722-1682 ■ www.trinityhand.com

Patient Information

Date: _____

Name: _____ (Last) _____ (First) _____ (Middle) _____ (Preferred Name/Nickname)

Date of Birth: _____ Age: _____ Sex: ◯ Male ◯ Female

Home Address: _____ (Street (include apartment or unit number)) _____ (City) _____ (State) _____ (Zip)

Mailing Address (if different): _____ (Street / PO Box) _____ (City) _____ (State) _____ (Zip)

Mobile Phone (including area code): _____ Okay to leave message? ◯ Yes ◯ No

Home Phone (including area code): _____ Okay to leave message? ◯ Yes ◯ No

Work Phone (including area code): _____ Ext: _____ Okay to leave message? ◯ Yes ◯ No

Preferred Email Address: _____

Social Security Number: _____

Preferred Pharmacy (name and phone #): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

May we leave a message with your emergency contact? ◯ Yes ◯ No

If you are being seen in our office for a work injury that has been ***pre-approved*** by your employer under workers' comp insurance, please specify your date of injury _____, and skip directly to the **PATIENT MEDICAL HISTORY** section.

Insurance Information

Do you have insurance? ◯ Yes ◯ No

If **YES**, we must have a copy of your insurance card on file to submit claims for you. It is your responsibility to update us **immediately** of any change in your insurance status or information.

If **NO**, we must have a "Self-Pay Agreement" on file for you before you are seen. Please request one from the receptionist.

Do you have Medicare? ◯ Yes ◯ No

If **YES**, we must have a "Medicare Part B Beneficiary Private Medical Contract" on file for you before you are seen. Please request one from the receptionist.

PRIMARY POLICY

Name of Insured: _____ Relationship to Patient: _____

Insurance Company: _____ Policy/ID #: _____

Employer: _____

If insured is NOT the patient, please complete the following:

Date of Birth: _____ Social Security Number: _____ Sex: ◯ Male ◯ Female

Address and Phone Number: _____

SECONDARY POLICY

Name of Insured: _____ Relationship to Patient: _____

Insurance Company: _____ Policy/ID #: _____

Employer: _____

If insured is NOT the patient, please complete the following:

Date of Birth: _____ Social Security Number: _____ Sex: ◯ Male ◯ Female

Address and Phone Number: _____

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Patient Medical History

Date: _____

Name: _____ _____ _____ _____
Last First Middle What you prefer to be called

Primary Care Physician: _____ Referring Physician: _____

Are you: ◯ **RIGHT** handed ◯ **LEFT** handed Height: _____ feet _____ inches Weight: _____ lbs

How did you hear about us or whom may we thank for your referral? _____

Employer: _____ Job Title/Occupation: _____

Reason for your visit: _____

How long have you had this problem? _____

Is the problem:

Related to injury/accident? ◯ Yes ◯ No
_____
If **YES**, please give date and type of injury

Related to your work or job? ◯ Yes ◯ No
_____
If **YES**, have you reported the injury to your employer?

Have you contacted an attorney? ◯ Yes ◯ No
_____
If **YES**, specify attorney name and phone number

Is this visit for a second opinion? ◯ Yes ◯ No
_____
If **YES**, who is requesting the second opinion?

The following two questions relate to prior treatment for this problem or for any other condition that could be related. In order for us to fully address your problem at your visit, it is important for us to obtain and review prior treatment records and test results **BEFORE** the date of your appointment. In order to request your records, we will need a completed "Authorization to Release PHI" form (located on the FORMS tab of our website) for each physician/facility where treatment was received.

Have you seen any other physician(s) for this problem (including ER or urgent care clinic)? ◯ Yes ◯ No

Have you had any diagnostic tests (i.e. x-ray, MRI or CT scans, electrical studies, etc.) for this problem? ◯ Yes ◯ No

Prior treatment details:

Have you ever experienced allergic reactions to the following?

- Latex ◯ Yes ◯ No
- NSAIDs (non-steroidal anti-inflammatory drugs) ◯ Yes ◯ No
- Antibiotics ◯ Yes ◯ No
- Analgesics (pain medications) ◯ Yes ◯ No

Describe any other drug allergies:

If you are being treated for an open injury, have you received a tetanus shot within the past ten years?

◯ Don't know ◯ No ◯ Updated on date of injury ◯ Yes

Do you take diet drugs/weight loss supplements? ◯ Yes ◯ No If **YES**, give details _____

Do you take any other medications/supplements? ◯ Yes ◯ No If **YES**, list **NAME AND REASON** for each below:

Have you experienced or been diagnosed with any of the following? If **YES**, please give details.

CONDITION	YES	NO	DETAILS
Allergies/immunological symptoms	◯	◯	
Anesthesia complications	◯	◯	
Anxiety/nervousness	◯	◯	
Arthritis/joint pain	◯	◯	
Back/neck pain	◯	◯	
Bleeding problems (including taking blood thinners)	◯	◯	
Depression/mood disorders	◯	◯	
Diabetes (if **YES**, what is the date and result of your most recent HbA1C?)	◯	◯	
Fibromyalgia or fatigue/tire easily	◯	◯	
GERD (esophageal reflux)	◯	◯	
Heart disease/hypertension/stroke/ high cholesterol/pacemaker	◯	◯	
Insomnia or difficulty sleeping due to hand pain	◯	◯	
Lung/pulmonary problems	◯	◯	

Have you ever had a surgery or procedure requiring anesthesia/sedation? ◯ Yes ◯ No

If YES, please list all major surgeries with approximate dates:

Family Medical History

Please mark all family members that have experienced or been diagnosed with the following:

CONDITION	FATHER	MOTHER	BROTHER	SISTER
Allergy	☐	☐	☐	☐
Anesthesia complications	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart disease/attacks	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐
Neurological disorders	☐	☐	☐	☐

Is there any further information we should know about your immediate family (father, mother, siblings) medical history?

Social History

Living arrangement (check one)
__◯__ alone
__◯__ with spouse, partner, roommate
__◯__ with parent, stepparent, relative, guardian
__◯__ assisted living or long-term care facility

Marital status (check one)
__◯__ single
__◯__ married
__◯__ divorced
__◯__ separated
__◯__ widowed
__◯__ other

# of children/dependents in the home

_____

Highest level of education (check one)
__◯__ elementary school
__◯__ junior high school
__◯__ high school
__◯__ college
__◯__ post-graduate

Hobbies and interests outside of work:

Job satisfaction (if employed outside the home, check one)
__◯__ low
__◯__ moderate
__◯__ high

Employment status (check all that apply)
__☐__ full-time
__☐__ part-time
__☐__ unemployed
__☐__ was working full-time until recently
__☐__ child (under 18)
__☐__ student
__☐__ disabled
__☐__ homemaker
__☐__ retired
__☐__ primary caregiver for spouse/parent/grandchild

 # years at current job

_____

Describe your alcohol use (check all that apply)
__☐__ none
__☐__ before bedtime
__☐__ social
__☐__ moderate
__☐__ heavy
__☐__ recovering alcoholic

Do you use tobacco products? __◯__ Yes __◯__ No
(If YES, check all that apply)
__☐__ cigarettes _____ packs per day
__☐__ e-cigarettes
__☐__ other tobacco forms

Drug abuse history (check all that apply)
__☐__ no
__☐__ yes
__☐__ recovering addict

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Patient Acknowledgements and Consents

_____ _____

Patient Name (print) Date

CONSENT TO TREAT: I voluntarily consent to and authorize the performance of any treatments, medications, anesthesia, medical services, and surgical or diagnostic procedures (including, but not limited to, the use of lab and radiographic studies) as ordered by Trinity Hand Specialists (THS). I understand that I may be asked to sign additional informed consent documents relating to specific procedures.

PAYMENT FOR SERVICES: I am responsible for all financial obligations of health services for the above patient. I agree to assign insurance benefits to THS. I understand that, as a patient courtesy, THS bills all insurance companies with whom they are contracted as a "network" provider. I acknowledge full financial responsibility for services rendered by THS and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, co-pays, deductibles, co-insurance, pre-existing clauses, excluded conditions, excluded services, and termination of coverage. I agree that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or other third-party payer is involved with payment. Because of contractual obligations between THS, my insurance company, and me, I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles – an estimate of these amounts will be made at each visit and collected on the date of service. Returned checks are subject to a $40 returned check fee.

By signing on page 2 of this document, I authorize my insurance company to pay the doctor all insurance benefits otherwise payable to me. In addition, I authorize the release of any information necessary to obtain payment from the insurance company. (We will use this as your signature on file to be used on all insurance claims.)

ADDING COLLECTION AGENCY FEES: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary.

AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS: I authorize and release THS and its employees and agents to take photographs, videos, x-rays, and/or other electronic images and to use them as may be medically appropriate. Such images may be used for educational purposes or other purposes as necessary and appropriate for my treatment. These images may be maintained as a permanent part of my medical record, and patient confidentiality will be maintained for all such images.

CONSENT FOR ELECTRONIC PRESCRIBING: I authorize THS to submit my prescriptions to my pharmacy using secure e-prescribing software. I further authorize access to my medical history, prescription history, and current medications from any and all health care providers.

DIAGNOSTIC STUDIES: I understand that THS can provide diagnostic studies/tests in our office. I understand that I have the option of choosing another facility for these services, if I so desire. THS will provide me with a list of other facilities at my request.

MEDICAL HISTORY ACCURACY AND COMPLETENESS: I understand that the healthcare professionals involved in my care will rely on my disclosed medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

_____ **By initialing here, I acknowledge that I understand and agree to the above policies and that I have the legal authority to sign this document.**

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Patient Acknowledgements and Consents

_____ _____

Patient Name (print) Date

AGREEMENT AS TO RESOLUTION OF CONCERNS: "Physician" shall be understood to mean Paul Gorman, MD, Trinity Hand Specialists, PLLC, and/or any of the THS clinical staff. I understand that I am entering into a contractual relationship with the Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I agree that any physicians retained by me or on my behalf will be expert witnesses in active, current full-time hand surgery practice, in good standing of the American Academy and Board of Orthopaedic Surgery (AAOS and ABOS) and the American Society for Surgery of the Hand (ASSH), and have a valid active Certificate of Added Qualification (CAQ) in Hand Surgery from ABOS. I agree that the expert will be obligated to adhere to the guidelines or code of conduct defined by the ABOS, AAOS, and ASSH. I also agree to require any attorney that I hire to agree to these provisions. In further consideration, Physician also agrees to exactly the same above-referenced stipulations; and both parties agree that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim. Patient/Guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses, and other dependents. Patient/Guardian and Physician agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery, or any other theory of recovery.

Patient is 18 or older – PATIENT ACKNOWLEDGEMENT:

By signing below, I acknowledge that all sections of this document (two pages) have been read in full and explained as necessary. I further acknowledge that I understand and accept the terms outlined in each of the eight policies.

_____ _____

Patient Signature Date

Patient is under 18 – LEGAL GUARDIAN ACKNOWLEDGEMENT:

By signing below, I acknowledge that all sections of this document (two pages) have been read in full and explained as necessary. I further acknowledge that I understand and accept the terms outlined in each of the eight policies. Furthermore, I affirm that I have the legal authority to sign this document.

_____ _____

Legal Guardian Name (print) Relationship to Patient

_____ _____

Legal Guardian Signature Date

TRINITY HAND SPECIALISTS ACKNOWLEDGEMENT:

By signing below, I agree to abide by the terms outlined in each of the eight policies on these two pages.

Paul Gorman, MD

Trinity Hand Specialists, PLLC

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of the *Notice of Privacy Practices*, which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Trinity Hand Specialists reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* at any time on our website, www.trinityhand.com, in our office, or by a request in writing.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Patient

_____

Printed Name of Representative

If a representative signs this document for the patient, please describe the representative's authority to act on behalf of the patient (**initial one**).

(_____) The representative is the parent of the patient, who is a minor.

(_____) The representative is the guardian of the patient, who has been adjudicated incompetent.

(_____) The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to THS personnel.

I understand that my protected health information will only be verbally communicated to those listed below. Those individuals will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individuals that you want protected health information given to:

_____ _____

_____ _____

FOR OFFICE USE ONLY

Reason Acknowledgement could not be obtained:

_____

_____

_____

_____ _____

Employee Signature Date