

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	_____	

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 CONCERNING 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