INSTITUTE for HAND & ARM SURGERY

**Virak Tan, MD**

345 Main Street
Suite 202
Madison, NJ 07940

620 Essex Street
Suite 202
Harrison, NJ 07029

Ph: (973) 947-4700
Fax: (888) 900-9262
HandArmSurgery.com

## CONFIDENTIAL PATIENT INFORMATION

Date of Visit: _____

**Physician:** _____

Last Name: _____ First Name:_____ Middle Initial:_____ DOB:_____
(Apellido) (Nombre) (Fecha de Nacimiento)

Address:_____ City: _____State: _____Zip: _____
(Direccion) (Ciudad) (Estado) (Codigo Postal)

Phone #: (C) _____ (H)_____ (W)_____
(Telefono) (Celular #) (Casa #) (Trabajo #)

Email: _____@_____

SS#._____ Sex: M___F___ Marital Status: Married Single Widowed Divorced/Separated
Seguro Social# (Sexo circule uno) (Estado Civil circule uno)

Employer:_____
Nombre y Direccion de Empleador (Name) (Address)

Referred by:_____
(Referido Por) (Name) (Nombre) (Address) (Direccion)

**Primary/Family Physician:** _____
(Primario/Medico de la Familia) (Name) (Nombre) (Address) (Direccion) (Tel. #)

Parents' names if under 18:_____
(Los padres si es menor de 18)

Mother's SS #:_____ Father's SS #:_____
(Madre SS #) (Padre SS #)

Emergency contact:_____Relationship:_____ Tel. #:_____
(Contacto de emergencia) (Relacion) (Telefono #)

Pharmacy name:_____ Address: _____
Tel. #: _____

Are you fully vaccinated against COVID-19? ☐**Yes** ☐**No**
(Usted esta vacunado/a contra COVID-19?)

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## Medical History

Date of Visit: _____

For Office Use Only

**PRN:** **Wt:** lbs. **Ht:** inches **BP:** / **Pulse:** **Temp:**

**Reason for your visit:** _____

_____

_____

_____

Which hand/arm is affected? Right Left Both

Which hand is your dominant hand? Right Left Both

How long have you had the problem? _____

How do you rate your pain (Circle one): no pain 1 2 3 4 5 6 7 8 9 10 severe pain

intermittent constant sharp dull stabbing burning electric daytime nighttime activity-related

Does anything improve your pain? _____

Have you had prior treatment for this problem? _____

Which hosp/clinic/doctor?

**Social History:**

Occupation: _____ Are you working? yes / no

Smoking: Never Former Current _____ pack(s)/day:_____ # years: _____

Alcohol: No Social Yes # of drink(s)/day: _____

**Past Medical History:** (please circle all that apply to you): [ ]None

| | | | | |
|---|---|---|---|---|
| Diabetes | Heart failure | Gout | Liver disease | HIV Positive |
| High blood pressure | Vascular disease | Multiple Sclerosis | Kidney disease | Depression |
| High cholesterol | Aneurysm | Enlarged prostate | Sleep apnea | Glaucoma |
| Thyroid disease | Anemia | Hepatitis: Type A B C | Emphysema | Rheumatoid arthritis |
| Heart disease | Bleeding disorder | Gastric Reflux | Asthma | Osteoarthritis |
| Heart attack (MI) | Seizure disorder | Stomach ulcer | Lyme disease | Stroke |

Cancer (types)_____

List any other medical conditions you have which are not listed above: _____

_____

**Past Surgical History:** _____

_____

**Family Medical History:**

Mother: _____
Father: _____
Sibling: _____

**Allergies:** _____ [ ] No Known Drug Allergy

_____

**Current Medications (with doses):** [ ] None [ ] See List

_____ _____
_____ _____
_____ _____
_____ _____

**Review of Symptoms** (Circle any other issue you are **currently** experiencing): **[ ]NONE**

*General*: weight change, change in strength or exercise tolerance, night sweats

*Neck*: stiffness, pain, tenderness

*Eyes*: vision change, double vision, tearing, blind spot, pain

*Ears*: change in hearing, ringing in ear, bleeding, balance disturbance

*Nose*: bleeding, obstruction, discharge

*Mouth*: dental difficulties, gingival bleeding, use of dentures

*Cardiovasc*: chest pains, chest tightness, palpitations, venous stasis

*Respiratory*: shortness of breath, wheezing, cough, bloody cough

*GI*: change in appetite, difficulty swallowing, abdominal pains, bowel habit changes, bloody stool

*Genitourinary*: kidney problems, burning or frequency with urination

*Skin*: change in skin mole, rash

*Neurologic*: weakness, tremor, seizures, changes in mentation, uncoordinated gait

*Psychiatric*: depressive symptoms, changes in sleep habits, changes in thought content

*Hematologic*: bleeding tendency, prolonged bleeding, deep vein thrombosis

*Allergic/Immunologic*: seasonal or contact allergies

**Patient's Signature:**_____ **Date:** _____

**Physician's Signature:**_____ **Date:** _____

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask us to correct that record. We will not reveal your record to others unless you direct us to do so. You are able to obtain more information by contacting our Office Manager.

Our Notice of Privacy Practices describes more in detail, how your health information may be used and revealed, and how you can obtain your information.

## YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I,_____, have received a copy of this Office's Notice of Privacy Practice's.
(Aviso de la Práctica de Privacidad)

Signature of patient or guardian:_____ Date:_____
(Firma del paciente o tutor) (Fecha)

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## CONSENT FOR TREATMENT

I hereby authorize the physicians at the *Institute for Hand & Arm Surgery* and whomever they may designate as assistant, to provide all treatment including rehabilitative therapy that is deemed necessary in relation to my present ailment. In order for my doctor to make an appropriate diagnosis, I have provided all necessary information regarding my present complaint, past medical history, hospitalization, medications, and any other information pertinent to my health.

At any time during the course of treatment, I will inform the doctor of any unusual changes to my health.

Signature of patient or guardian:_____ Date:_____
(Firma del paciente o tutor) (Fecha)

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## Authorization for Use or Disclosure of Patient Photographs and/or Videos

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the *Institute for Hand & Arm Surgery*. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising. I understand that I may revoke this authorization at any time, but such revocation must be in writing. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

I understand that the Institute for Hand & Arm Surgery cannot condition treatment on whether or not I sign this authorization.

Signature of patient or guardian:_____ Date:_____
(Firma del paciente o tutor) (Fecha)

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# AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I,_____, authorize the offices of the *Institute for Hand & Arm Surgery*
(Patient name/Nombre del paciente)

to disclose to_____
(Person to whom disclosure is made/Persona a la que la divulgación se hace)

my medical records to the following extent:

_____

_____
(treatment dates, name of health care facility which treatment was provided; types of records to be excluded, if any)

for_____.
(Purpose of disclosure/Propósito de la divulgación)

**I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV), that my signing this document authorizes Institute for Hand and Arm Surgery to release that information.**

**I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege.**

This consent may be revoked at any time in writing to – *Institute for Hand & Arm Surgery*, except to the extent that the *Institute for Hand & Arm Surgery* has already taken action in reliance on it. If not previously revoked, this consent will terminate upon 99 years from the date signed. *Institute for Hand & Arm Surgery* will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization.

I acknowledge and understand that uses and disclosures of my health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentiality laws.

Signature of patient or guardian:_____ Date:_____
(Firma del paciente o tutor) (Fecha)

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# Out of Network Notice

**We are out-of-network providers for ALL Commercial Health Benefit Plans.** This notice is to confirm that you have been advised that the physicians at the *Institute for Hand & Arm Surgery* are non-participating with your insurance carrier.

The fee for the office visit(s) and/or surgery will be billed to your insurance company. This fee does not include Xm rays, injections, durable medical equipment, casts, therapy, etc. These are additional.

Since we are out-of-network with your insurance company, please be advised that there is a possibility that check(s) for our services will be sent directly to you. Please endorse these checks, payable to: *Institute of Hand & Arm Surgery* and mailed to our office as soon as possible. It is important that you include the "Explanation of Benefits" sheet with the check(s) to ensure that payment(s) is(are) posted properly to your account. The mailing address is:

Institute for Hand & Arm Surgery
345 Main Street, Suite 202
Madison, NJ 07940

We can give a receipt for your visit to submit to your insurance carrier, or we would be happy to submit the claim for you, whenever possible.

In the event that surgery is warranted during the course of your treatment, we will contact your insurance carrier. We will obtain a pre-certification for the surgical procedure, verify your benefits and negotiate the surgical fee. However, there may be expenses that may become your responsibility. In addition to the physician's charges, there may be facility, radiology and pathology charges, which are not part of our services.

**Our Affiliated Surgical Facilities are:** Harrison Endo Surgical Center, Overlook Medical Center.

If your insurance company denies your claim or does not respond with proper payment in a timely fashion, your excellent assistance will be necessary in the appeal process in reminding your insurance company about their responsibility in making prompt payment.

**The physicians at the *Institute of Hand & Arm Surgery* are out-of-network providers with your insurance.**

I, _____, acknowledgment the above information:

_____ _____
Signature Date

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## PATIENT FINANCIAL POLICY

Our practice goal is to be your partner in providing care. Letting you know in advance our Financial Policy provides for a good flow of communication and enables us to achieve that goal. **Please read this carefully**. If you have any questions, do not hesitate to ask a member of our staff.

1. We request that you present your current insurance card upon arrival to your initial visit and notify us of any changes on subsequent visits.
2. **According to your insurance plan, you are responsible for any and all co-payments, deductibles, co-insurances and medical services not covered by your plan**.
3. **It is your responsibility to understand your benefit plan** and to know if a written referral or pre-authorization is required. Our staff is available to help.
4. **If we do not participate in your insurance plan or you do not have insurance, payment in full is expected. You agree that payment of insurance benefits for all services rendered to you are to be made on your behalf to Institute for Hand & Arm Surgery. *Outstanding balances must be paid prior to a scheduled visit.***
5. **Certain insurance carriers will send our payment directly to your home address. It is expected that you will forward that payment to our office, along with the Explanation of Benefits.**
6. Co-pays are due at the time of service. A $10 processing fee may be charged in addition to your co-pay, if the co-pay is not paid at the time of service.
7. You have an option of having a credit or debit card number stored securely with our office. **IF YOU DECLINE THE CREDIT-CARD-ON-FILE OPTION, OR THE CARD IS INVALID OR EXPIRED AT THE TIME OF CHARGE, OUR OFFICE WILL ASSESS A FEE OF ONE PERCENT (1%) FOR EACH MONTH ON ANY UNPAID BALANCE NOT COVERED BY INSURANCE WHICH IS NOT PAID WITHIN THIRTY (30) DAYS OF OUR STATEMENT.**
8. We will invoice you after receipt of your insurance plan's Explanation of Benefits if there is a balance due. Your payment is due **10 business days from receipt of your statement**. Any balance past due for 45 days or longer will be turned over to our collection agency unless other payment arrangements have been made with us.
9. **A fee of $40 will be charged if you miss a confirmed appointment or fail to cancel an appointment at least 24 hours in advance.** A new appointment will not be made, unless we have your credit card on file.
10. **Patients who accumulate three (3) no shows/same day cancellations within a 12-month period will automatically be terminated from our practice.** Exceptions may be made depending on the specific circumstances.
11. Our secure patient portal is available online. This service allows access to medical records, direct communication with your doctor, and on-line request for appointments.
12. A **$45 fee** will be charged for any checks returned. Additional fees from the bank may also be charged.
13. If you have forms to be completed, there is a charge. Payment is due when the forms are dropped off. We require a minimum one-week turnaround time for those forms.

**I, _____, understand and agree to the Patient Financial Policy.**

X_____ Date_____
Signature of Patient or Responsible Party

**I authorize Institute for Hand & Arm Surgery to charge the portion of my bill that is my financial responsibility to the following credit or debit card. I agree to pay such amount according to my credit issuer agreement (merchant agreement if credit voucher). We reserve the right to charge a 3% fee for credit card payments.**

**Date: _____ □AMEX □VISA □MasterCard □Debit Amount: $_____**

Credit/Debit Card # _____ CVN # _____ Exp. Date _____

Cardholder Name _____ Signature _____

Billing Address _____