LOREDO HAND
CARE INSTITUTE

DEMOGRAPHICS

Patient Name: _____ DOB: _____

SSN: _____-_____-_____ Driver's License #: _____ State: _____

Home#:_____ Mobile#:_____ Email Address: _____

Mailing Address: _____Apt#: ____City: _____State: _____ Zip: _____

Employer Name: _____ Address: _____

Work Number: _____Occupation: _____

Person to notify in case of emergency: _____ Contact #:_____

Primary Care Physician: _____ Phone#: _____

Pharmacy _____ City/Phone Number _____

How did you hear about us? _____

FINANCIAL INFORMATION

Primary Insurance Co._____ Tel # _____

Insurance ID# _____ Group # _____

Insured's Name _____ Insured's Date of Birth _____ Relationship to Patient _____

Secondary Insurance Co._____ Tel # _____

Insurance ID# _____ Group # _____

Insured's Name _____ Insured's Date of Birth _____ Relationship to Patient _____

Assignment Authorization/Office Fee Policy

I hereby authorize ___Loredo Hand Care Intisitute_____, to release to my insurance company, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical care. I authorize and request my insurance company to pay directly to the doctor the amount due for my pending claim for medical services, by reason of such treatment or services rendered to me a photographic copy of this authorization shall be as the original. It is the policy of this office that the parent/guardian accompanying the child for treatment services will be responsible for all bills. We cannot bill the other parent. We respectfully request payment of any deductible, coinsurance and/or co-payment at the time the service is rendered regardless of insurance coverage. If any insurance payments are received by our office that is due to the patient, a refund will be made to the patient.

Signature: _____Relationship to patient: _____Date: _____

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History:

Height:_____ Weight:_____

Drug Allergies:

_____

Do You Drink Alcohol? _____ Do You Smoke? _____ Use Recreation Drugs?_____

If So How Much/Often: _____

Do You Have Any Health Issues: (Please Circle)

High Blood Pressure **High Cholesterol** **Fibromyalgia** **Breathing Problems** **Diabetes**

Migraine Headaches **Keloid Scars** **Shortness Of Breath** **Depression/Anxiety**

Any Heart Issues: **Palpitations** **A-Fib** **Stents** **Heart Attack** **Heart Flutters**

Other: _____

Past Surgical History: **(**Please list name of all procedures and dates.)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Any Problems With Anesthesia? _____

Medications: (Prescription and Over the Counter Medications)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Do You Take Any Blood Thinners/Vitamin E/Fish Oil/Phentermine/Aspirin? _____

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Review of Systems: (Please circle yes or no.)

General:

Changes in weight	Yes	No
Progressive/Prolonged Fatigue	Yes	No

Pulmonary:

Cough	Yes	No
Shortness of breath	Yes	No
Wheeze	Yes	No
Snoring	Yes	No

Cardiac:

Do you ever wake up short of breath	Yes	No
Leg/ Ankle swelling	Yes	No
you sleep okay	Yes	No
Palpitations / Heart flutters	Yes	No
Abnormal sensation with exertion/ chest, arms, neck, back)	Yes	No

Infectious Disease:

Fever	Yes	No
Night Sweats	Yes	No
Recent Infection	Yes	No

Gynecologic/Urologic:

Incontinence	Yes	No
Difficulty / Painful urination	Yes	No
Blood in urine	Yes	No

Psychiatric:

Suicidal thoughts	Yes	No
Hallucinations	Yes	No
Memory loss	Yes	No
Feeling depressed/anxious	Yes	No

Blood/Lymph:

Easy bruising	Yes	No
Frequent nose bleeds	Yes	No
Swollen glands	Yes	No

Head and Neck:

Decrease in hearing	Yes	No
Ringing in the ears	Yes	No
New Headaches	Yes	No
Sinus Problems	Yes	No
Sore throat	Yes	No
Changes in voice	Yes	No
Dry mouth	Yes	No

Eyes:

Blurred vision	Yes	No
Eye pain	Yes	No
Redness	Yes	No
Watering	Yes	No
Light sensitive	Yes	No
Dry feeling	Yes	No

Gastrointestinal:

Frequent Nausea / Vomiting	Yes	No
Abdominal pain	Yes	No

Skin:

Changing moles	Yes	No
New rash	Yes	No
Tendency to form Keloid	Yes	No

Neurological:

Dizziness	Yes	No
Difficulty walking	Yes	No
Sensory changes	Yes	No

Musculoskeletal:

Weakness / Numbness	Yes	No
Neck / Back Pain	Yes	No
TMJ / Jaw Pain	Yes	No

ACKNOWLEDGEMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Loredo Hand Care Institute of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient Name: _____ **Patient Signature:**_____ **Date:**_____

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Hand And Elbow History:

What Do You Do For A Living? _____

Which Hand/Arm Hurts? ◯ **Right** ◯ **Left** ◯ **Both**

How Long Has It Been Going On? _____

What Gives You Issues?:(Circle All That Apply) Wrist Forearm Hand Thumb Index Finger

Middle Finger Ring Finger Small Finger Elbow

Do You Have Numbness And Tingling? ◯ YES ◯ NO

How Severe Is Your Pain?: **None** **Mild** **Moderate** **Severe**

How Severe Is Your Weakness?: **None** **Mild** **Moderate** **Severe**

Have you had any prior treatment for your condition? ◯ Yes ◯ No

If yes, please indicate which treatments you have tried:

	YES	NO	Did This Help?/ Describe
Anti-Inflammatory/ Pain Medications			
Splints			
Cortisone Injections			
Physical Therapy			
Chiropractic			
Surgery			
Other			

Have You Had An EMG/Nerve Study Done In The Past? _____

If so where was it done at _____

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INSURANCE ACKNOWLEDGMENT, HIPPA & ENDORSEMENTS

- **Acknowledgement of Practice's *Notice of Privacy Practices*:**

I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms. To file a complaint with the Texas Medical Board call 1-800-201-9353.

- **RECORDS RELEASE**

I hereby authorize ***Loredo Hand Care Institute*** to furnish any medical records and/or other necessary information needed to process an insurance claim.

- **ASSIGNMENT OF BENEFITS**

I, the undersigned, am the financially responsible party for the patient named above and agree to pay, in full, ***Loredo Hand Care Institute,*** for services rendered. I accept ***Loredo Hand Care Institute*** fees as reasonable and customary.

Should your insurance deny payment for any and all services you are responsible for the amount billed.

- **WORKMANS COMP & NON-WORKMANS COMP DECLARATION**

PLEASE READ - THE PHYSICIAN IS UNABLE TO DETERMINE WHETHER OR NOT THE SYMPTOMS YOU ARE SUFFERING ARE WORK RELATED. It is your responsibility as the patient to notify our office if you file a work comp claim. You also understand that should your workman's comp claim be denied, you will be responsible for all balances in full. If group health insurance is available, we must receive a copy for processing as soon as you are aware the claim has been denied. This is not a guarantee that we accept your group insurance.

- **X-Ray & Ultrasound**

I, authorized Loredo Hand Care Institute to take x-rays and preform an ultrasound for my condition.
I understand my x-rays and ultrasound and other pertinent information related to my treatment will be presented for analysis. I further understand this information is valuable in order to assist my doctor in his evaluation of an initial treatment plan, as well as modification to this plan during the course of treatment.

_____ _____ _____

Patient Name DOB **Signature of Responsible Party** **Date**

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OWNERSHIP AND REFERRAL DISCLOSURE FORM

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services.

This Disclosure Form is designed to help ensure that patients have the necessary information to make an informed decision about their medical benefits and care. A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient, and whether these are available elsewhere on a competitive basis; patients also should be informed whether provider to which they are referred are out of network. Patients shall be given a list of effective alternative resources, if any, that are reasonably available, informed that they have the option to use one of the alternative resources, and assured that they will not be treated differently by the physician if they choose an alternative provider or entity.

PATIENT REQUEST FOR AND CONSENT TO OUT OF NETWORK REFERRAL

I have the choice of using a participating health care facility/provider. If I choose to use a doctor or health care facility that does not participate in my network, my health insurance may not cover the services if my plan does not have out-of-network benefits. If my plan has out-of-network benefits, I understand that by using my out-of-network benefits I may have higher out-of-pocket costs that I will be responsible to pay. I hereby request and consent to my referral to the provider named above.

PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

☒ In compliance with the requirements of law, you are being advised that I/we may have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services that we may order for you.
☒ I/we may have a financial interest in the health care professional or health care facility that we take you to do surgery
☒ I receive medical directorship from Texas General Hospital, Crescent Medical Center, Peak Health Surgicare
☒ I am the marketing manager for IOM Hand (Neuromonitoring Company)

PATIENT ACKNOWLEDGMENT OF FINANCIAL INTEREST

☒ I have the choice to use a health care provider in which my physician does not have an ownership interest, provided such a healthcare provider is available. I wish to utilize a health care provider in which my physician has an ownership/investment interest, as described in this disclosure form.
☒ MY DISCLOSURES/INVOLVEMENT WITH SURGERY CENTERS/MEDICAL DIRECTORSHIP/NEUROMONNITORING DIRECTORSHIP/ INVESTMENTS OF SURGICAL CENTERS/ OTHER INVOLVEMENTS WERE ALL EXPLAINED TO THE PATIENT. ALL THEIR QUESTIONS AND CONCERNS WERE ADDRESSED. CHOICES WERE GIVEN TO THE PATIENT AND THE PATIENT WANTED TO MOVE FORWARD WITH PLANNED TREATMENTS.

_____	_____	_____
Patient Printed Name DOB	**Patient signature**	**Date**

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PHYSICIAN-PATIENT AGREEMENT

Loredo Hand Care would like to provide you with the comprehensive health care. This care will include:
Scheduled visits with Loredo Hand Care and/or one of the nursing staff, who will serve as the coordinator of your medical care.
Cancellation with 24 hours and No Shows are subject to a $25.00 fee which is not covered by insurance.
Medication as prescribed by Loredo Hand Care.
Consultations with other care providers as requested by Loredo Hand Care.
Diagnostic and treatment procedures as order by Loredo Hand Care.
To provide appropriate medical care, your cooperation is necessary. Your cooperation will be demonstrated by your agreeing and adhering to the following points

- I will notify the clinic at least one (1) day before missing any scheduled clinic visit.
- I will participate in the evaluation and treatment plans as agreed to with Loredo Hand Care.
- I will inform Loredo Hand Care about all health care and medication I receive from sources other than Loredo Hand Care and agree to any communication between health care providers about my care. I further agree that I will not obtain any pain medications of any type from any other physician other than Loredo Hand Care and I will not change pharmacies without prior consent. Any violation of the above will result in immediate discharge.
- My family and I will treat the staff of Loredo Hand Care with respect and demonstrate that respect by refraining from loud, abusive, or threatening language or behavior in the office or on the phone.
- I understand that Loredo Hand Care cannot safely provide routine medical care if I fail to comply with any component of this agreement. Should I fail to comply with this agreement, Loredo Hand Care will no longer be able to provide regular medical care or medications.

My Signature below indicates my agreement with this plan.

Patient Name: _____ DOB : _____

Patient Signature: _____ Date: _____

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HIPPA RELEASE FORM

Patient Name: _____ DOB: _____

Release Of Information

__ I authorize the release of information including the diagnosis, records, examination rendered to me and claim information.

This information may be released to:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call:

____ Home: _____
____ Work: _____
____ Cell: _____

If unable to reach me:

____ You may leave a detailed message
____ Please leave a message asking me to return your call
____ Do not leave a message

Signature: _____ Date: _____