~Welcome to our Office ~

First Name: Last Name:	Today 3 Date.	-		a .	
City:	First Name:	Last Nan	ne:		Male/ Female
Home Phone:	Street Address:			Date of Birth: _	
[Billing Address [if different]:	City:	State:	Zip:	_ Cell Phone: _	
Emergency Contact Person:	• р	*		Home Phone: _	
E-mail:	(Billing Address (if different): _)
Would you like a reminder of your appointment(s) sent to you? By Text: yes/no By E-mail: yes/no Date of Incident/Injury: Date of Surgery: Describe Incident/Injury: Primary Care Physician: Referring Physician: Primary Insured's Name: Auto Claim Primary Insured's Name: Morkers Comp Claim: Employer Name/Address/Phone: Consent to Treat/ Bill Insurance I hereby consent and authorize The Pittsburgh Shoulder to Hand Center to treat my condition and to bill my insurance company. The care provider will explain my condition to me, along with treatments and alternative methods of treatment. I authorize the care provider to perform any additional/different treatment, as necessary, should a condition be discovered which was not previously known. I understand that I may, and should, ask my provider any questions I may have regarding my care. I have carefully read and fully understand this Informed Consent Form. I also understand that I will have the opportunity to discuss my condition and the procedures described to me with the care provider. Signature of Patient/Legal Guardian Date Office Use Only: Case: Diagnosis:	Emergency Contact Person:		Phone:	R	elationship:
Date of Incident/Injury:	E-mail:	·	How did yo	ou hear about us?	
Referring Physician: Primary Care Physician: Insurance Company: Primary Insured's Name: Auto Claim Insured's DOB: Workers Comp Claim: Employer Name/Address/Phone: Hereby consent and authorize The Pittsburgh Shoulder to Hand Center to treat my condition and to bill my insurance company. The care provider will explain my condition to me, along with treatments and alternative methods of treatment. I authorize the care provider to perform any additional/different treatment, as necessary, should a condition be discovered which was not previously known. I understand that I may, and should, ask my provider any questions I may have regarding my care. I have carefully read and fully understand this informed Consent Form. I also understand that I will have the opportunity to discuss my condition and the procedures described to me with the care provider. Signature of Patient/Legal Guardian Date Office Use Only: Case: Diagnosis:	Would you like a reminder of yo	our appointment(s) sent to you?	By Text: <u>yes/no</u>	By E-mail: <u>yes/no</u>
Insurance Company: Primary Insured's Name: Auto Claim Insured's DOB: Workers Comp Claim : Employer Name/Address/Phone: Hereby consent and authorize The Pittsburgh Shoulder to Hand Center to treat my condition and to bill my insurance company. The care provider will explain my condition to me, along with treatments and alternative methods of treatment. I authorize the care provider to perform any additional/different treatment, as necessary, should a condition be discovered which was not previously known. I understand that I may, and should, ask my provider any questions I may have regarding my care. I have carefully read and fully understand this Informed Consent Form. I also understand that I will have the opportunity to discuss my condition and the procedures described to me with the care provider. Signature of Patient/Legal Guardian Date Office Use Only: Case: Diagnosis:	Date of Incident/Injury:		Date of Surgery:	-	<u>.</u>
Insurance Company: Auto Claim	Describe Incident/Injury:				:
Auto Claim Insured's DOB: Workers Comp Claim: Employer Name/Address/Phone: Consent to Treat/ Bill Insurance I hereby consent and authorize The Pittsburgh Shoulder to Hand Center to treat my condition and to bill my insurance company. The care provider will explain my condition to me, along with treatments and alternative methods of treatment. I authorize the care provider to perform any additional/different treatment, as necessary, should a condition be discovered which was not previously known. I understand that I may, and should, ask my provider any questions I may have regarding my care. I have carefully read and fully understand this Informed Consent Form. I also understand that I will have the opportunity to discuss my condition and the procedures described to me with the care provider. Signature of Patient/Legal Guardian Date ***********************************	Referring Physician:		Primary Ca	re Physician:	
Auto Claim Insured's DOB: Workers Comp Claim: Employer Name/Address/Phone: Consent to Treat/ Bill Insurance I hereby consent and authorize The Pittsburgh Shoulder to Hand Center to treat my condition and to bill my insurance company. The care provider will explain my condition to me, along with treatments and alternative methods of treatment. I authorize the care provider to perform any additional/different treatment, as necessary, should a condition be discovered which was not previously known. I understand that I may, and should, ask my provider any questions I may have regarding my care. I have carefully read and fully understand this Informed Consent Form. I also understand that I will have the opportunity to discuss my condition and the procedures described to me with the care provider. Signature of Patient/Legal Guardian Date ***********************************					
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**************************************	I hereby consent and authorize a company. The care provider will treatment. I authorize the care pe discovered which was not premay have regarding my care. I hereby consent and authorize a company to the care provided the care provided the care provided to the care provided the car	The Pittsburgh Shou explain my condition provider to perforn eviously known. I un ave carefully read	on to me, along wit n any additional/dif nderstand that I ma and fully understan	th treatments and alt ferent treatment, as ay, and should, ask m d this Informed Cons	ernative methods of necessary, should a condition y provider any questions lent Form. I also understand
Office Use Only: Case: Diagnosis:	-		-		
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iviedical History (p	lease check all that apply)		e a
Chills	Dizziness/Fainting	Damussia (Alam	
Sweats	Forgetfulness	Depression/Nervousness	High/Low blood pressure
Headache		Numbness	Irregular/Rapid heartbeat
Fever	Chest pain	Varicose veins	Poor circulation
rever	Loss of sleep	Loss of weight	Swelling of Ankles
Pain, weakness &/or	numbness in: Arms Feet	Back Hips Legs Hands	_ Shoulders _ Neck
Please List: Curren	nt Medications:		
Allergi			
Alleigi	съ.		
	<u>Please Rea</u>	d Over the Following & Sig	n Below
~ Patients are res			d up-to-date insurance information in
order to hill their Ir	Isurance Company Pation	to are responsible for all deductible	a up-to-date insurance information in
covered "items" /i.	surance company. Patient	is are responsible for all deductible	les, co-pays, and co-insurances. Non-
covered items (i.i	e. putty, coban, bandages)	will be told of ahead of time, if a	pplicable.
Although we	to our best to advise pat	ients of any out of pocket expe	enses up front, this is not always
possible when it c	omes to copays, co-insur	ances and deductibles. Thus, y	ou are responsible for knowing your
co-pays and plan	coverage. (Please call tl	he number on your insurance co	ard with any questions.)
Any account	balances sent to Collectic	ons will have a \$10/mth (from da	ate of service) added to it's balance.
D. A. B. SERVINGS OF THE PROPERTY OF THE PROPE	c		
~ In order for The	Pittshurah Shoulder to H	and Center to provide you with the	e best care possible, we ask that you
make every offert t	s keep scheduled anneint	and center to provide you with the	e best care possible, we ask that you
make every enough	o keep scheduled appointi	ments and to arrive in a timely ma	anner. Although we realize that
emergencies may a	irise, we ask that you give	us a call to let us know. If you do	not show for a scheduled appointment,
The Pittsburgh Sho	ulder to Hand Center reser	ves the right to bill you \$35 for ea	ich NO SHOW appointment.
8			
Consistent atte	endance is important in ach	nieving recovery If your attendan	nce is inconsistent, the referring physicia
case manager and	/or insurance company ma	who contacted to notify them of	inconsistent patient compliance. In the
case of Worker's Co	omponention cases benefit	to make be effected to notify them of	inconsistent patient compliance. In the
case of worker 5 Co	ompensation cases, benefit	ts may be affected at the discretion	on of the insurance carrier.
	Martin April 1981	·	Management of the control of the con
	Patient Sig	gnature	Date
* 1			
		•	
9			
Acknowledgement	of Receipt of Our Notice	of Privacy Practices	
By signing below, I	acknowledge that I have h	een provided with a copy of The	Pittsburgh Shoulder to Hand Center's
Notice of Drivery D	acknowledge that I have b	een provided with a copy of the	Pittsburgh Shoulder to Hand Center's
Notice of Privacy Pi	ractices and have therefore	e been advised of how health info	ormation about me may be used and
disclosed by The Pi	ttsburgh Shoulder to Hand	Center and how I may obtain acco	ess to and control this information.
-	*		
	Patient/Personal Repr	esentative Signature	Date
** "			*
Please list below	/ tne names of who you pe	rmit to access your pertinent med	dical information:
** Preferred metho	od of contacting you? Pho	ne#	
			your answering machine/voicemail.
		in our stair to leave illessages on	your answering machine/voicemail.