~Welcome to our Office ~

Today's Date: _____

First Name: _____ **Last Name:** _____ **Male ____ / Female ____**

Street Address: _____ **Date of Birth:** _____

City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

Home Phone: _____

(Billing Address (if different): _____**)**

Emergency Contact Person: _____ **Phone:**_____ **Relationship:** _____

E-mail: _____ **How did you hear about us?** _____

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: _____

Referring Physician: _____ **Primary Care Physician:** _____

Insurance Company: _____ **Primary Insured's Name:** _____

_____ **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**

****

Office Use Only: Case: _____ **Diagnosis:** _____

Cause: ____ Surgery ____ Auto ____ Fall ____ Work ____ Sports Injury ____ Other: _____

Medical History (please check all that apply)

___ Chills	___ Dizziness/Fainting	___ Depression/Nervousness	___ High/Low blood pressure
___ Sweats	___ Forgetfulness	___ Numbness	___ Irregular/Rapid heartbeat
___ Headache	___ Chest pain	___ Varicose veins	___ Poor circulation
___ Fever	___ Loss of sleep	___ Loss of weight	___ Swelling of Ankles

Pain, weakness &/or numbness in: ___ Arms ___ Back ___ Hips ___ Shoulders ___ Feet ___ Legs ___ Hands ___ Neck

Please List: Current Medications: _____

Allergies: _____

Please Read Over the Following & Sign Below

~ Patients are responsible for providing our office with correct, complete and up-to-date insurance information in order to bill their Insurance Company. Patients are responsible for all deductibles, co-pays, and co-insurances. Non-covered "items" (i.e. putty, coban, bandages) will be told of ahead of time, if applicable.

Although we do our best to advise patients of any out of pocket expenses up front, this is not always possible when it comes to copays, co-insurances and deductibles. Thus, you are responsible for knowing your co-pays and plan coverage. (Please call the number on your insurance card with any questions.)

Any account balances sent to Collections will have a $10/mth (from date of service) **added to it's balance.**

~ In order for *The Pittsburgh Shoulder to Hand Center* to provide you with the best care possible, we ask that you make every effort to keep scheduled appointments and to arrive in a timely manner. Although we realize that emergencies may arise, we ask that you give us a call to let us know. If you do not show for a scheduled appointment, *The Pittsburgh Shoulder to Hand Center* reserves the right to bill you $35 for each NO SHOW appointment.

~ Consistent attendance is important in achieving recovery. If your attendance is inconsistent, the referring physician, case manager, and/or insurance company may be contacted to notify them of inconsistent patient compliance. In the case of Worker's Compensation cases, benefits may be affected at the discretion of the insurance carrier.

_____ _____

Patient Signature ***Date***

Acknowledgement of Receipt of Our Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of *The Pittsburgh Shoulder to Hand Center's* Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by *The Pittsburgh Shoulder to Hand Center* and how I may obtain access to and control this information.

_____ _____

Patient/Personal Representative Signature ***Date***

** Please list below the names of who you permit to access your pertinent medical information:

_____ _____ _____

** Preferred method of contacting you? Phone# _____

** _____ Please check (__) if you do not want our staff to leave messages on your answering machine/voicemail.