DESERT HAND ASSOCIATES
SURGERY OF THE HAND AND UPPER EXTREMITY
ERIC L. FREEDMAN, M.D.

Patient Registration Form

Date: _____

Name of patient (please print): _____ DOB: _____
Patient's address: _____
Street City State Zip code
Home phone: ( ) _____ Cell phone: ( ) _____
Email: _____ Social Security #: _____

Marital status: Single Married Widowed Divorced Separated Sex: M / F

Occupation: _____ Employer name: _____
Employer address: _____
Street City State Zip code phone
Spouse's name: _____ DOB: _____ SS#: _____
Spouse's employer: _____ Work phone: _____

If patient is a minor, responsible adult: _____
Address (if different) _____ phone: _____
Social Security no: _____ DOB: _____ relation: _____

What is your present complaint? _____
Date of injury? _____ Related to: Auto Work Other _____

Emergency contact: _____ relation: _____
Address: _____ phone: _____

How did you hear about us? _____

Primary insurance information: _____
Name policy/group I.D. #

I hereby authorize Eric L. Freedman, M.D. to furnish the above insurance company all information which said insurance company may request concerning my illness or injury. I hereby assign to Eric L. Freedman M.D. all payments to which I am entitled for medical and/or surgical expense relative to the services reported for the above. I understand I am financially responsible to said doctors for my portion of allowed charges, charges applied to my deductible or charges not covered by my policy. If monthly payments become past due, I agree to pay the total amount owing upon demand and to pay reasonable service charges, collection cost, attorney fees, and court cost as permitted by law. I understand I will be charged a $15.00 service fee for any returned checks.

_____ _____
Date Patient or legal guardian

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General Health Questionnaire

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Race (optional): _____

Are you Right or Left Handed? (circle one)

List all current treating physicians: _____

Pharmacy info: _____

Chief Complaint: List the medical problem(s) which have lead you to seek medical help today, and a brief history on how it began:

_____

_____

_____

Do you have any drug allergies?: Y / N If yes, what are they?:

_____

List **all** current medications and dosage (include herbs/supplements/vitamins):

1.
2.
3.
4.
5.
6.
7.
8.

Do you have any illnesses/medical problems/health conditions?:

Heart problems/diabetes/elevated cholesterol/high blood pressure
Other: _____

List all previous surgeries/procedures and dates:

_____

_____

Do any conditions run in your family? (Circle or write in)

Diabetes/cancer/leukemia/tuberculosis/heart trouble/high blood pressure/stroke/anemia/bleeding tendency/kidney disease/_____

Are you (circle one): Married Single Widowed Divorced Significant other

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How many children do you have? _____

Are you employed? Y / N Full time or Part time

What is your occupation? _____

If you are not employed, when did you last work? _____

Are you disabled? Y / N Did you retire? Y / N when? _____

Do you drink alcohol? Y / N Quantity: _____

Are you a smoker? Y / N How long? _____ Packs per day: _____

Were you previously a smoker? Y / N How long ago? _____

Review of systems

Do you or have you ever had any of the following problems?:

Skin:	
Skin infections or boils?	Y / N
Sores that do not heal?	Y / N
Change in skin moles?	Y / N
Head:	
Recent severe headaches?	Y / N
Blackout or fainting spells?	Y / N
Convulsions or epilepsy?	Y / N
Eye, Ear, Nose, and Throat:	
Difficulty or pain with swallowing?	Y / N
Glaucoma?	Y / N
Ear infections?	Y / N
Trouble with balance?	Y / N
Breast: (both women and men)	
Do you have a lump or tumor now?	Y / N
Have you ever had discharge from a nipple?	Y / N
Heart and Lungs:	
Does shortness of breath limit mobility?	Y / N
Frequent cough?	Y / N
Emphysema?	Y / N
Chest pain or discomfort?	Y / N
Leg cramps at night?	Y / N
Leg aches when walking?	Y / N
Tuberculosis?	Y / N
Pneumonia?	Y / N
Coughing up of blood?	Y / N
Heart attack or coronary problems?	Y / N
Do you prop yourself up to sleep?	Y / N
Angina?	Y / N

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Blood clots?	Y / N
Abnormal EKG?	Y / N
Heart murmur?	Y / N
High blood pressure?	Y / N
Varicose veins on legs?	Y / N
Swollen ankles?	Y / N
Inflamed veins (thombophlebitis)?	Y / N
Stomach and bowels:	
Pain, indigestion or heartburn?	Y / N
Cramps in the stomach or abdomen?	Y / N
Bloody or black bowel movements?	Y / N
Are you currently taking iron?	Y / N
Frequent loose stool or diarrhea?	Y / N
Recent change in bowel habits?	Y / N
Stomach, duodenal or peptic ulcer?	Y / N
Hepatitis or cirrhosis?	Y / N
Kidney and Bladder:	
Do you get up often at night to urinate?	Y / N
Has urination been painful recently?	Y / N
Have you ever had a kidney infection?	Y / N
Do you lose control of your bladder?	Y / N
Have you ever had kidney stones?	Y / N
Glands:	
Sugar diabetes?	Y / N
Sugar in urine or blood?	Y / N
A thyroid disorder?	Y / N
Other glandular problems?	Y / N
Blood:	
Swollen glands in armpits, neck or groin?	Y / N
Excessive bleeding with operations?	Y / N
A diagnosis of 'bleeder'?	Y / N
A diagnosis of anemia?	Y / N
Nervous System:	
Ever had numbness of your arms or legs?	Y / N
Ever lost control of your hands or legs?	Y / N
Ever had a stroke or paralysis?	Y / N
Often been tense / nervous / depressed or worried?	Y / N
Been treated for emotional problems?	Y / N
Muscles and Bone:	
Recent severe back pain?	Y / N
Arthritis?	Y / N
A bone infection (osteomyelitis)?	Y / N
Recent joint swelling or pain?	Y / N
A broken bone?	Y / N
Gout?	Y / N

Do you have any other problems that have not already been mentioned? If so, please specify:

_____

_____

_____

FOR OFFICE USE ONLY

RT -

Grips and pinches: LT –

_____

Eric L. Freedman, M.D. Date

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A LETTER REGARDING MEDICAL INSURANCE

As you are aware, there have been many changes in the insurance coverage for physician services during the past few years. A major impact has been a dramatic increase in paperwork required to secure payment. Time constraints have forced us to make a change in our office policy.

Therefore, our office will no longer send invoices to patients for balances or co-payments for services rendered. We will require a credit card number to be kept on file. When Explanation of Benefit forms are received from your insurance carrier which indicate the appropriate co-payment due, we will bill your credit card directly for those fees.

As a courtesy to our patients, we will continue to bill insurance carriers for services provided at our office, whether or not we are a provider for that carrier.

I would be happy to discuss any questions you might have regarding our office policy. Your understanding of our response to this difficult problem is greatly appreciated.

Sincerely,

Eric L. Freedman, M.D.
Desert Hand Associates

_____
Print patient's name and/or card holder's name (if different)

_____
Cardholder's signature Date

Credit card type: Visa Mastercard American Express

Credit card number: _____

Expiration date: _____

CVR (3 digit # on back of card / AMEX 4 digit # on front of card): _____

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HIPAA Notice of Privacy Practices

Desert Hand Associates

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____