Idaho Hand CENTER

PATIENT INFORMATION SHEET

For Office Use Only:
Appt Date: _____
Sched With: _____
Acct #: _____
Entered by: _____

PERSONAL INFORMATION					
Last Name	First Name		M.I.	Preferred Name	
Address			City, State, Zip		
Date of Birth	Gender ☐M ☐F	Social Security #	Marital Status ☐Single ☐Married ☐Divorced ☐Widowed		
Primary Phone	Cell Phone		Email		
Patient's Employer		Occupation		Work Phone	
Emergency Contact Name		Relationship to Patient		Phone Number	
Primary Care Physician		Referring Physician			

If Patient is under the age of 18			
Father's Name	Date of Birth	Employer	Primary Phone
Mother's Name	Date of Birth	Employer	Primary Phone

INSURANCE INFORMATION					
Primary Insurance Information					
Primary Insurance Carrier	Policy Number		Group Number		
Subscriber Name	Subscriber DOB		Subscriber Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other		
Secondary Insurance Information					
Secondary Insurance Carrier	Policy Number		Group Number		
Subscriber Name	Subscriber DOB		Subscriber Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other		
Worker's Compensation Information					
Is this a work related injury? ☐Yes ☐No	Date of Injury	Claim Number			
Worker's Compensation Carrier	Case Manager/Adjuster		Contact info (phone or email)		

_____ _____
SIGNATURE OF PATIENT DATE

(PATIENT MUST BE 18 YEARS OR OLDER TO SIGN) PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE

PLEASE READ AND INITIAL THE FOLLOWING		
CONSENT FOR TREATMENT/RELEASE OF INFORMATION: I hereby authorize Idaho Hand Center (IHC) to provide treatment. I authorize IHC to release information from my medical record, including information about my treatment to a third party payer or a designated review agency for the purpose of processing my claim.		Initial:
HIPAA ACKNOWLEDGEMENT: I hereby acknowledge that I have been offered a copy of Idaho Hand Center's Notice of Privacy Practices and have been given a copy if requested.		Initial:
PAYMENT AGREEMENT: All services rendered are charged to the patient. IHC will file your claim if you have supplied us with insurance information in a timely manner. Co-pays, deductible, or percentage amounts are due at the time of service unless advance arrangements have been made with IHC. A payment must be made on balances every 30 days thereafter to avoid a billing fee. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will be sent to an outside billing service. Payment arrangements may be set up with the billing service for a $20 service fee and finance charge of up to 18%. If payment arrangements cannot be agreed upon, the amount due will be considered delinquent and can be subject to legal action or assignment to a collection agency. Collection fees and interest will accrue if account is turned for collection. Returned/NSF check fees apply.		Initial:
MISSED/LATE APPOINTMENTS: Missed appointments or late notice cancellations are a significant cost to the practice. I understand that as a courtesy to all of the patients in the clinic, if I am more than 10 minutes late for my appointment it can be rescheduled. I understand that multiple no-show or rescheduled appointments are grounds for dismissal from the practice.		Initial:
PERMISSION TO SHARE PROTECTED HEALTH INFORMATION: IHC maintains the confidentiality of all our patients. We respect an individual patient's right to decide who may receive information about their treatment, results, appointment times, and/or anything pertinent to their health as it relates to information held on file or with the physicians/staff here at IHC. By identifying below who you are authorizing to receive protected health information about you, we will respect your wishes and only release information to them. We recognize that circumstances change; you are allowed to revise this document at any time. I hereby allow the doctors and/or staff of IHC to release appropriate protected health information on myself to the following people:		
Name:	Relationship:	Initial:
Name:	Relationship:	Initial:
Name:	Relationship:	Initial:
Name:	Relationship:	Initial:
ASSIGNMENT OF BENEFITS (NON-MEDICARE): I hereby authorize payment directly to Idaho Hand Center of all healthcare benefits and understand that I am financially responsible for all charges, whether or not they are paid by insurance.		Initial:
ALL MEDICARE OR MED-ADVANTAGE POLICYHOLDERS MUST READ AND SIGN: (Signature Block #12 CMS 1500 Form) I request that payment of authorized Medicare benefits be made, on my behalf, to *IDAHO HAND CENTER AND ITS PROVIDERS* for any services furnished me by that physician/provider/supplier. I authorize any holder of medical information about me to be released to CMS Medicare/Noridian and/or to any authorized MedAdvantage Plan any information needed to determine these benefits or the benefits payable for related services. PATIENT'S SIGNATURE:_____ Date:_____		

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND VOLUNTARILY AGREE TO ITS PROVISONS.

_____ _____

PRINT PATIENT'S NAME DATE

_____ _____

SIGNATURE OF PATIENT (or Parent/Guardian if patient is under 18) RELATIONSHIP TO PATIENT