

Hand Surgery and Rehabilitation Center of New Jersey

PATIENT RESPONSIBILITIES

You have specific rights guaranteed by NJ State Law. Along with these rights, exist the following patient responsibilities:

1. **Be considerate** of other patients by allowing them privacy and maintaining a quiet atmosphere.
2. **Ask for explanations** of any medical problem or treatment plan, if you do not have a clear understanding. Once you have agreed to a treatment plan, it is important that you **follow the prescribed plan**. You may specifically want to ask:
 - Why a treatment is recommended
 - What alternatives are available
 - Whether the treatment causes discomfort or pain
 - How long the treatment will last
 - What risks are involved
3. You should not make any decisions about your care if you feel you are not fully informed. You may be asked to give your consent in writing to certain tests, procedures or operations. Ask as many questions as you need, to fully understand each document you are asked to sign. If you change your mind or refuse a treatment, discuss your reasons with your physician.
4. As a partner in your health care, we encourage you to:
 - **Be honest**-Provide an accurate and complete medical history
 - **Understand**-Ask questions of the healthcare team whenever necessary
 - **Follow the plan**- Tell the staff if you feel you cannot comply with the plan
 - **Report Change**-Tell the doctor if there is a change in your health
 - **Know your medications**-If possible, have a list of what medications you take and why
 - **Know your staff**-Try to know the names of everyone who cares for you
5. **Do not smoke in the facility**
 - **Pay your bill in a timely fashion.**

Your cooperation is appreciated

For any assistance with understanding these responsibilities, please do not hesitate to call us.

Thank you
Kathleen Flynn, Patient Relations Representative
856-983-4263, ext. 107



Hand Surgery & Rehabilitation Center

Comprehensive care...all within your reach.

**ACKNOWLEDGEMENT OF RECEIPT OF
HAND SURGERY AND REHABILITATION CENTER OF NEW JERSEY, P.A.
NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of Hand Surgery and Rehabilitation Center of New Jersey, P.A.. Notice of Privacy Practices.

Patient or Personal Representative Signature: _____

Patient Name: _____ Date: _____

Name of Personal Representative, if applicable: _____

HAND SURGERY AND REHABILITATION CENTER OF NEW JERSEY, P.A. USE ONLY

Date of receipt of signed acknowledgement: _____

If signed acknowledgement not received, document good faith efforts used to obtain:



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FINANCIAL AGREEMENT/OFFICE POLICY ON MANAGED CARE PROGRAMS

Providing quality care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at **EACH TIME OF SERVICE** exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirements in your contract and we subsequent order services such as x-rays, testing, medical supplies, therapy or hospitalization that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. With your cooperation and help, you should be able to receive all of the benefits offered to you and we will be able to concentrate on your medical needs.

- (1) I understand that regardless of my assigned insurance benefits, I am responsible for all charges incurred for all dates of service.
- (2) I understand that if I do not have insurance benefits, that I am responsible for all charges incurred for all dates of service.
- (3) I agree to pay my bill upon receipt of statement and to pay any assessed fee if my account is placed in collections.
- (4) I agree to pay reasonable attorney's fees for all costs of collection in the event the account is past due and is placed for collection.

WORKMAN COMPENSATION PATIENTS: The above only applies if we are denied payment through your worker's compensation carrier.

INJECTIONS MAY NOT BE COVERED BY YOUR INSURANCE PLAN. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR PLAN.

DO NOT SIGN THIS AGREEMENT UNTIL YOU READ AND UNDERSTAND IT. YOU ARE ENTITLED TO A COPY OF THIS AGREEMENT.

I have read and understand the above Agreement and agree to accept responsibility as described.

Patient Name

Patient ID#

Signature of Responsible Party/Legal Guardian

Date

Printed name of above

www.thehanddoctors.com

PATIENT HEALTH SURVEY
Hand Surgery & Rehabilitation Center

Patient Name: _____ DOB _____

In order to provide the proper medical and surgical care for your upper extremity, we need a complete review of your medical history. Please answer each question fully.

Are you currently suffering from?

- Frequent headaches Yes No Comment _____
- Impaired vision Yes No Comment _____
- Difficulty swallowing Yes No Comment _____
- Impaired hearing Yes No Comment _____
- Nosebleeds Yes No Comment _____

- Cough Yes No Comment _____
- Shortness of breath Yes No Comment _____
- Wheezing Yes No Comment _____

- Chest pain Yes No Comment _____
- Palpitations Yes No Comment _____

- Nausea/vomiting Yes No Comment _____
- Diarrhea Yes No Comment _____
- Constipation Yes No Comment _____
- Indigestion Yes No Comment _____
- Abdominal Pain Yes No Comment _____

- Bloody urination Yes No Comment _____
- Painful urination Yes No Comment _____
- Flank Pain Yes No Comment _____
- Urethral discharge Yes No Comment _____

- Numbness in feet Yes No Comment _____
- Numbness in hands Yes No Comment _____
- Poor balance Yes No Comment _____
- Difficulty walking Yes No Comment _____
- Seizures Yes No Comment _____
- Tremors Yes No Comment _____
- Weakness Yes No Comment _____
- Neck pain Yes No Comment _____
- Joint pain Yes No Comment _____
- Joint swelling Yes No Comment _____
- Dry eyes/dry mouth Yes No Comment _____
- Skin rashes Yes No Comment _____
- Morning stiffness greater Yes No Comment _____
 Than ½ hours

Have you had or do you currently suffer from?

- | | | | |
|-----------------------------|-----|----|--------------|
| • Migraines | Yes | No | Comment_____ |
| • Tinnitus | Yes | No | Comment_____ |
| • Cataracts | Yes | No | Comment_____ |
| • Glaucoma | Yes | No | Comment_____ |
| | | | |
| • Asthma | Yes | No | Comment_____ |
| • Bronchitis | Yes | No | Comment_____ |
| • Pneumonia | Yes | No | Comment_____ |
| • COPD | Yes | No | Comment_____ |
| | | | |
| • Angina | Yes | No | Comment_____ |
| • Myocardial infarction | Yes | No | Comment_____ |
| • Stroke | Yes | No | Comment_____ |
| • Hypertension | Yes | No | Comment_____ |
| • Arrhythmias | Yes | No | Comment_____ |
| • Valvular heart disease | Yes | No | Comment_____ |
| | | | |
| • Colitis | Yes | No | Comment_____ |
| • Cholecystitis | Yes | No | Comment_____ |
| • Pancreatitis | Yes | No | Comment_____ |
| • Hepatitis | Yes | No | Comment_____ |
| • GERD | Yes | No | Comment_____ |
| | | | |
| • Kidney stones | Yes | No | Comment_____ |
| • Prostate Hypertrophy | Yes | No | Comment_____ |
| • Bladder/kidney infections | Yes | No | Comment_____ |
| | | | |
| • Cancer | Yes | No | Comment_____ |
| • Anemia | Yes | No | Comment_____ |
| • Blood clotting disorders | Yes | No | Comment_____ |
| | | | |
| • Osteoporosis | Yes | No | Comment_____ |
| • Thyroid Disease | Yes | No | Comment_____ |
| • Diabetes Mellitus | Yes | No | Comment_____ |
| | | | |
| • Lyme Disease | Yes | No | Comment_____ |
| • Arthritis | Yes | No | Comment_____ |
| • Herniated spinal disc | Yes | No | Comment_____ |

Please list your previous operations:

Do you have a history of sleep apnea? Yes No

If yes, explain_____

Do you have a family history of difficulty waking up from anesthesia? Yes No
If yes, explain _____

Do you have a family history of malignant hyperthermia? Yes No
If yes, explain _____

Do you have any history of prolonged nausea/vomiting after anesthesia? Yes No
If yes, explain _____

Do you have any history of problems with breathing during or after anesthesia? Yes No
If yes, explain _____

Loose teeth or dentures? Yes No

Please list any allergies you may have (Drug, Food, Materials etc):

Please list your current medications and dosages:

Patient/Legal Guardian Signature _____ Date _____

Hand Surgery and Rehabilitation Center of New Jersey
Patient Bill of Rights

Hand Surgery and Rehabilitation Center of New Jersey endeavors to treat all patients with dignity, respect and courtesy. The patient has the right to not be discriminated against because of age, race, religion, sex, nationality or ability to pay.

Patients are afforded privacy for their persons and their protected health information as directed by HIPAA. The patient medical record is treated confidentially. Hand Surgery and Rehabilitation Center will not release medical records unless we have patient authorization except as required otherwise by law. You as the patient have the right to approve or disapprove release of your medical record.

We strive to provide to you, a person designated by you, or a legally authorized person, in terms that can be understood, your diagnosis, treatment plan, alternative methods of treatment, prognosis, as well as the natural history of the condition left untreated. We request that the patient act responsibly in their treatment plan and comply with treatment recommendations. Failure to do so can impact adversely on the desired clinical results

The patient has the right to participate in decisions involving their healthcare. Patients have the right to refuse medication and treatment. Such refusal shall be documented in the patient medical record.

Hand Surgery and Rehabilitation Center provides hand and upper extremity evaluations, surgical and non-surgical treatment of hand and upper extremity conditions. Such treatment may include hand therapy with various treatment modalities. We are pleased to provide a state-of-the-art hand surgical facility premises to those patients requiring surgery. We also provide radiographic evaluations and fluoroscopic evaluations of the hand, wrist and forearm unit where indicated and have the capability neurometric evaluations when indicated.

A physician from the practice is available 24 hours a day, 7 days a week and can be reached by dialing the main office number (856) 983-4263.

Patients have the right to be informed if the facility has authorized other health care professionals to participate in the patient's treatment. The patient shall also have the right to refuse to allow their participation in their treatment.

Fees for Services are available to patients. Hand Surgery and Rehabilitation Center provides various payment alternatives to patients who may be experiencing hardship. If there are any questions as it relates to your bill, please feel free to consult with a member of our Billing Department.

If a patient has a grievance, this can be expressed verbally to their physician or in writing to the organization. Any grievances will be investigated, documented and the patient will be provided with a written notice of the decision made regarding the grievance. The patient may also contact the New Jersey Office of the Medicare Beneficiary Ombudsman at 1-877-582-6995 or by accessing the website at www.medicare.gov.

The patient has a right to request another physician within the practice if they are uncomfortable for whatever reason. If a patient requests a second opinion from another hand surgeon or hand group, we would be happy to provide a referral accordingly.

The patient has the right to be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time. Drugs and medications shall not be used for discipline of patients or for convenience of facility personnel.

The patient has the right to not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient.

The patient has the right to exercise civil and religious liberties, including the right to independent personal decisions.

The patient has the right to expect and receive appropriate assessment, management and treatment of pain as an integral component of their care.

Hand Surgery and Rehabilitation Center does not participate in experimental research.

Hand Surgery and Rehabilitation Center does not accept Advance Directives.

The Hand Surgery and Rehabilitation Center Ambulatory Surgery Center is owned in partnership by the surgeons that comprise the Governing Body. A list of each surgeon's name is available upon request.

Signature _____

Date _____

HSRC PATIENT REGISTRATION
(Please print and fill out completely)

DATE: _____ MEDICAL RECORD # _____

Patient name: _____ M / F Age: _____

If Minor, Name of Parent or Legal Guardian _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____

Home Phone#: _____ Cell#: _____

E-Mail Address: _____

Emergency Contact and Phone #: _____

To whom can we speak with regarding your medical care?(Spouse, family, etc). _____

Date/place of injury: (i.e.; work, auto, other): _____

Describe symptoms: _____

Employer Name/Address: _____

Occupation: _____ Work phone# _____

SUBSCRIBER PRIMARY INSURANCE INFORMATION: (who carries the insurance policy)

Subscriber Name: _____ Date of birth: _____ SS#: _____

Employer name/address: _____

Name/Address of insurance company: _____

ID#: _____ Group#: _____ Phone#: _____

SECONDARY INSURANCE INFORMATION

Subscriber Name: _____ Date of birth: _____ SS#: _____

Employer name/address: _____

Name/Address of insurance company: _____

ID#: _____ Group#: _____ Phone#: _____

WORKERS COMPENSATION INFORMATION

Date of Injury: _____ Claim#: _____ Phone#: _____

Insurance Company name/address: _____

PRIMARY or REFERRING PHYSICIAN

Primary or Referring MD name: _____ Phone#: _____

Address: _____

I acknowledge that if prescribed a narcotic, I will not drive, operate any machinery or make any important decisions.

Signature _____

I authorize the use or disclosure, as appropriate, of my individually identifiable health information by Hand Surgery and Rehabilitation Center of New Jersey, to my insurance carriers, legal representatives, my attorney, and referring Physician. If worker's comp, I authorize the use or disclosure, as appropriate, of my individually identifiable health information to my employer, rehab nurse, and insurance company. I authorize my insurance benefits to be paid if applicable directly to the above-signed physician, realizing I am responsible to pay any non-covered benefits and, including but not limited to co-payments and deductibles.

Date: _____ Patient/Parent/Legal Guardian Signature _____