



Hand Surgery & Rehabilitation Center

Comprehensive care...all within your reach.

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.

Height _____ Weight _____ Are you Right __ or Left __ Handed

Do you consume: Alcohol ___ Tobacco ___

ARE YOU CURRENTLY SUFFERING FROM?

- Migraines/headaches Yes No Comment _____
- Impaired vision Yes No Comment _____
- Difficulty swallowing Yes No Comment _____
- Impaired hearing/ringing in ears Yes No _____

- Bleeding Disorder Yes No Comment _____
- Lung Disease Yes No Comment _____
- Wheezing/Shortness of breath Yes No _____
- Chest pain Yes No Comment _____

- Nausea/vomiting Yes No Comment _____
- Diarrhea/Constipation Yes No Comment _____
- Indigestion/reflux Yes No Comment _____
- Abdominal Pain 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 _____
- Tremors Yes No Comment _____
- Neck pain Yes No Comment _____
- Joint pain/ Yes No Comment _____
- Joint Swelling/stiffness Yes No Comment _____
- Dry eyes/dry mouth Yes No Comment _____
- Skin rashes Yes No Comment _____

HAVE YOU HAD OR DO YOU CURRENTLY SUFFER FROM?

- Migraines Yes No Comment_____
- Seizures 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_____
- Lung Disease Yes No Comment_____

- Angina/chest pain Yes No Comment_____
- Heart Attack Yes No Comment_____
- Stroke Yes No Comment_____
- High Blood Pressure Yes No Comment_____
- Arrhythmias Yes No Comment_____
- Heart Disease Yes No Comment_____
- Irritable Bowel Syndrome Yes No Comment_____
- Gallbladder disease Yes No Comment_____
- Pancreatitis Yes No Comment_____
- Hepatitis/Liver Disease Yes No Comment_____
- Acid Reflux Yes No Comment_____

- Kidney stones Yes No Comment_____
- Prostate Enlargement Yes No Comment_____
- Bladder/kidney infections Yes No Comment_____
- Gout Yes No Comment_____
- High Cholesterol Yes No Comment_____
- Cancer Yes No Comment_____
- Low Blood Count Yes No Comment_____
- Bleeding disorders Yes No Comment_____

- Osteoporosis Yes No Comment_____
- Thyroid Disease Yes No Comment_____
- Diabetes Yes No Comment_____

- Lyme Disease Yes No Comment_____
- Arthritis Yes No Comment_____
- Spine/Disc Yes No Comment_____
- _____



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**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

A PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Each patient receiving service in an ambulatory care facility shall have the following rights and responsibilities:

1. Each patient has the right to be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. Each patient has the right to be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. Each patient has the right to be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;
4. Each patient has the right to receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
5. Each patient has the right to participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
6. Each patient has the right to be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
7. Each patient has the right to voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;
8. Each 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 to protect the patient or Patient Rights or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;
9. Each patient has the right to confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
10. Each patient has the right to be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;
11. Each 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. Such work shall be in accordance with local, State and Federal laws and rules;
12. Each patient has the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient; and
13. Each patient has the right to not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.
14. It is the responsibility of the Center to know and understand the patient's bill of rights and responsibilities.
15. Patient will receive a signed copy of the "Patient's Bills of Rights and Responsibilities" and the original document will be maintained in Medical Records.
16. Since effective treatment depends in part on patient's history, the center expects the patient or the patient's family to provide information about past illnesses, hospitalizations, medications, and other pertinent matters.
17. The Center expects the patient will ask questions about directions or procedures they don't understand.
18. The Center expects the patient to be considerate of other patients and staff in regard to noise, smoking, and number of visitors in the patient areas. The patient is also expected to respect the property of the Center and of other persons.
19. To help the patient's physicians and the Center staff care for the patient, the patients are expected to follow instructions and medical orders and report unexpected changes in their condition to their physician and Center staff.
20. The patient assumes financial responsibility for all services either through their insurance or by paying at the time of service.
21. The patients are expected to follow all safety regulations that they are told or read about.
22. If the patient fails to follow their healthcare provider's instructions, or if the patient refuses care, they are responsible for their own actions.
23. Except for emergencies, the practitioner shall obtain the necessary informed, written consent prior to the start of specified non-emergency procedures or treatments only after a physician has explained - in terms that the patient understands - specific details about the recommended procedure or treatment, the risks involved, the possible duration of incapacitation, and any reasonable medical alternatives for care and treatment. (N.J.A.C. 8:43G-4.1(a) 7.) Informed consent is required by the State of New Jersey. (N.J.A.C. 8:43A-13.3(a)16.)
24. A patient or, if the patient is unable to give informed consent, a responsible person, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program, and the patient, or responsible person, shall give informed consent prior to actual participation in the program. A patient, or responsible person, may refuse to continue in a program to which he has previously given consent.
25. The patient who does not speak English shall have access, where possible, to an interpreter.

26. The patient can choose to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.
27. As a Person with Pain, You Have:
- a) The right to have your report of pain taken seriously and to be treated with dignity and respect by doctors, nurses, pharmacists and other healthcare professionals.
 - b) The right to have your pain thoroughly assessed and promptly treated.
 - c) The right to be informed by your doctor about what may be causing your pain, possible treatments, and the benefits, risks and costs of each.
 - d) The right to participate actively in decisions about how to manage your pain.
 - e) The right to have your pain reassessed regularly and your treatment adjusted if your pain has not been eased.
 - f) The right to be referred to a pain specialist if your pain persists.
 - g) The right to get clear and prompt answers to your questions, to take time to make decisions, and to refuse a particular type of treatment if you choose.

If you believe you have received improper care or would like to file a complaint contact:
New Jersey Department of Health and Senior Services (DHSS), Complaint section at (800) 792-9770
Medicare Ombudsman at www.cms.hhs.gov/center/ombudsman.asp or 1-800-MEDICARE (1-800-633-4227)

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: _____ Pharmacy _____ Town _____

Home Phone#: _____ Cell#: _____

E-Mail Address: _____ SS# _____

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#: _____

Circle One: Male or Female _____ Does this insurance require a referral? YES OR NO

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 _____