

Date: _____

Please fill out all information.

Patient Information

Last Name _____ First Name _____ Middle _____ Preferred/Nickname _____

DOB: ____/____/____ Gender: M F SS#: ____-____-____ Marital Status: _____

Address _____ City/State Zip _____ County _____

Phone Numbers:

Home _____ Work _____ Cell _____ Primary _____ Email _____

Guarantor Information: (Please complete if patient is under the age of 18.)

Last Name _____ First Name _____ Initial _____ SS#: ____-____-____

Address _____ City/State Zip _____

Phone Numbers: Home _____ Work _____ DOB _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Information

Insurance Company (Primary) _____ Policy Number _____ Group Number _____

Insured _____ Relationship to Patient _____ SS# _____

DOB _____ Address _____

Employer Name _____ Work Status _____ Occupation _____ Phone/Ext _____

Employer Address _____ City/State/Zip _____

Insurance Company (Secondary) _____ Policy Number _____ Group Number _____

Insured _____ Relationship to Patient _____ SS# _____

DOB _____ Address _____

Employer Name _____ Work Status _____ Occupation _____ Phone/Ext _____

Employer Address _____ City/State/Zip _____

Was this a work related injury?

Yes No

Employer at time of injury

Date of Injury

Was injury reported?

Yes No

Date injury reported

Consent to Treat: I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by The Hand Center, PA ("HC") its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at HC.

Consent to the use or Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations.
I consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered to me, treatment and healthcare operation consistent with HC's Notice of Privacy Practices.

I authorize my insurance carrier to make payment directly to HC. I understand that I am responsible for any balance due on my account not covered by my insurance. Thus, if the account balance is not satisfied with 30 days after the first notification the account may be referred for legal action.

The patient or guarantor is responsible for all fees associated with collection of past due accounts including any collection fee.

Signature

Date

Witness

Date

DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION (PHI)

I authorize The Hand Center to disclose my personal health information to the person/persons listed below:

Name

Relationship to Member/Dependent

Name

Relationship to Member/Dependent

I would like this authorization to expire on: _____. If no expiration date is provided,
Month / Day / Year
this authorization will expire twelve (12) months from the date of form.

Signature

Date

Print your full name