BROWARD HAND CENTER

HARRIS GELLMAN M.D.
PURNELL TRAVERSO M.D.

Surgery of the Hand and Upper Extremity in Adults and Children

Dear Patient:

Due to the many changes insurance policies, it has become increasingly more difficult to interpret each individual policy. Although we constantly try to stay abreast of these changes, it is not always possible. Therefore, we urge you as the patient, to please check with your insurance company regarding your coverage. **It is your responsibility to know your individual coverage**. Failure to comply with our suggestion could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company, **not** between your doctor and your insurance company.

Many insurance companies today need referral forms from a primary care physician or group. **It is the responsibility of the patient to make sure we receive the referral by the day of the appointment**. Some insurances state you **cannot** go out of the network. Many companies have instituted a mandatory secondary opinion program, and these are constantly changing day by day. We simply cannot keep up with these seemingly inexhaustible changes and often are not aware of them until after the fact.

Many insurances must use labs that are "in network" (part of that insurance group), and we may not know which those are; what may be correct for one group may not be correct for another.

Please call your insurance company and learn about your coverage; it will save a lot of confusion, heartache and money for you in the long run.

DECLARATION:

If my insurance company does not pay, I agree to be personally and fully responsible for the payments due. If this becomes delinquent and past due, I agreed to pay all costs of collection including interest, court costs, attorney fees and collection fees.

_____

Print name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date: MM DD YYYY

3100 Coral Hills Drive, Suite 305
Coral Springs, FL 33065
(O): 954-575-8056 (F): 954-575-2563

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PATIENT INFORMATION

PLEASE PRINT

NAME _____ _____ _____ MARITAL STATUS _____
(First) (MI) (Last)

HOME PHONE# (_____) _____ CELL PHONE# (_____) _____

DATE OF BIRTH _____/_____/_____ AGE _____ E-MAIL ADDRESS _____
MM DD YYYY

OCCUPATION _____ Soc.Sec.No. _____-_____-_____ SEX: M F
Circle

EMPLOYER _____ Business Phone# (_____) _____

ADDRESS _____ _____ _____ _____
Street City State Zip

Permanent Resident of Florida? YES _____ NO _____
(If answer is no please list 2nd address)

ADDRESS _____ _____ _____ _____
Street City State Zip

PARENT OR LEGAL GUARDIAN'S NAME _____ MARITAL STATUS _____
(First) (MI) (Last)

ADDRESS _____ _____ _____ _____
Street City State Zip

PHONE# (_____)_____ Soc.Sec.No. _____-_____-_____ D.O.B._____/_____/_____
MM DD YYYY

Please list the name of a person to contact in case of an emergency other than a spouse or parent:

NAME _____ _____ _____ RELATIONSHIP _____
(First) (MI) (Last)

ADDRESS _____ _____ _____ _____
Street City State Zip

PRIMARY INSURANCE

NAME OF COMPANY _____ PHONE#(____)_____ Effective Date _____/_____/_____
MM DD YYYY

ADDRESS _____ _____ _____ _____
Street City State Zip

INSURED'S NAME _____ D.O.B. _____/_____/_____ Soc.Sec.No. _____-____-_____
(First) (MI) (Last) MM DD YYYY

GROUP NO. _____ ID# _____ Relationship to Insured _____

SECONDARY INSURANCE

NAME OF COMPANY _____ PHONE#(____)_____ Effective Date _____/_____/_____
MM DD YYYY

ADDRESS _____ _____ _____ _____
Street City State Zip

INSURED'S NAME _____ D.O.B. _____/_____/_____ Soc.Sec.No. _____-____-_____
(First) (MI) (Last) MM DD YYYY

GROUP NO. _____ ID# _____ Relationship to Insured _____

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION/FINANCIAL AGREEMENT. I, the undersigned, knowing the patient, (minor) and/or self, is suffering from a condition requiring health care, diagnosis and/or medical treatment hereby voluntarily agree to such diagnostic procedure and healthcare assignees. I authorize the release of medical information to my referring doctor, health agency, government agency, insurance company or worker's compensation. I request that payment to insurance benefits made on my behalf be paid directly to Dr. Harris Gellman / Dr. Purnell Traverso. I assume full financial responsibility for all debts incurred in any treatment and follow-up care received. I understand that any unpaid patient balances will be assessed at the interest rate of 1.5% per month.

I understand that no guarantee or assurance has been made as to the results of the procedure or treatment and that it may not cure the condition.
It is the patient's responsibility to obtain authorization from their Primary Care Physician or insurance company (if required by insurance company) **prior** to services being rendered.

Patient's or Legal Guardian's Signature _____ **Date** _____/_____/_____
MM DD YYYY

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DATE: _____/_____/_____
MM DD YYYY

PATIENT NAME: _____
(FIRST) (M) (LAST)

CELL PHONE: (____) - _____

MAY WE SEND YOU A TEXT MESSAGE? : YES ___ NO ____

IF NO CELL PHONE: _____

HOW FAR ARE YOU FROM THE OFFICE (IN MINUTES): _____

PRIMARY/FAMILY PHYSICIAN: _____

DR'S PHONE: (____) - _____

FAX: (____) - _____

ADDRESS: _____ _____
Street Suite

_____ _____ _____
City State Zip Code

REFERRING PHYSICIAN: _____

DR'S PHONE: (____) - _____

FAX: (____) - _____

ADDRESS: _____ _____
Street Suite

_____ _____ _____
City State Zip Code

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MEDICAL QUESTIONNAIRE

PATIENT'S NAME _____ _____ _____ AGE _____ SEX: M F
(First) (MI) (Last) Circle

REASON FOR TODAY'S VISIT: _____

_____

HOW LONG HAVE YOU BEEN EXPERIENCING THESE SYMPTOMS? _____

ARE YOU?: ☐RIGHT-HANDED ☐LEFT-HANDED ☐AMBIDEXTROUS

WHAT DID YOU INJURE? ☐THUMB ☐HAND ☐ELBOW ☐OTHER: _____
☐FINGER ☐WRIST ☐SHOULDER

WHAT SIDE?: ☐RIGHT ☐LEFT

DATE OF INJURY ___ / ___ / _____ DATE YOU LAST WORKED: ___ / ___ / _____
MM DD YYYY MM DD YYYY

CURRENT WORK STATUS (CHECK ALL THAT APPLY): ☐NOT WORKING ☐LIGHT DUTY ☐FULL DUTY
☐**SEDENTARY** ☐**DISABLED**

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? ☐YES ☐NO

IF YES, WHAT FOR? _____

LIST ALL MEDICATIONS: _____

_____

_____

_____

_____

ALLERGIES: _____

_____

PREVIOUS SURGERIES: ☐APPENDIX ☐BREAST ☐COSMETIC ☐EAR/NOSE/THROAT
☐GALL BLADDER ☐HEART ☐OB/GYN ☐PROSTATE
☐STOMACH/BOWEL ☐THYROID ☐TONSILS ☐VASCULAR

☐PRIOR ORTHOPEDIC SURGERY (WITH DATES): _____

☐OTHER: _____

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DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

YES / NO	YES / NO	YES / NO	YES / NO
☐ ☐ AIDS/HIV	☐ ☐ PSYCHIATRIC	☐ ☐ DIABETES	☐ ☐ CANCER
☐ ☐ ANGINA ☐ ☐	SEIZURES ☐ ☐	HYPERTENSION	☐ ☐ STROKE
☐ ☐ ARRHYTHMIA	☐ ☐ STOMACH ULCER	☐ ☐ LOW BACK PAIN	☐ ☐ URINARY TRACT INFECTION
☐ ☐ ASTHMA	☐ ☐ DEPRESSION	☐ ☐ MIGRAINES	☐ ☐ TUBERCULOSIS
☐ ☐ BIRTH DEFECTS	☐ ☐ EMPHYSEMA	☐ ☐ PHLEBITIS	☐ ☐ HEADACHES
☐ ☐ BLOOD CLOTS/EMBOLISM	☐ ☐ HEART MURMURS	☐ ☐ BLOOD TRANSFUSION	☐ ☐ HEART ATTACK
☐ ☐ PNEUMONIA	☐ ☐ HEPATITIS	☐ ☐ BRONCHITIS	

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH PER WEEK? _____

ARE YOU PREGNANT? ☐ YES ☐ NO ☐ NOT APPLICABLE

DO YOU HAVE A FAMILY HISTORY OF ANY MEDICAL CONDITIONS? (PLEASE LIST)

_____

_____

_____

PLEASE LIST ANY OTHER INFORMATION YOU THINK MAY BE HELPFUL/IMPORTANT?

_____

_____

_____

EMERGENCY CONTACT:_____ **RELATIONSHIP:** _____

PHONE: (_____) - _____

THE INFORMATION I HAVE GIVEN ABOVE IS COMPLETE AND ACCURATE. AS WITH ALL MEDICAL RECORDS, THE INFORMATION YOU HAVE PROVIDED WILL BE CONFIDENTIAL.

_____ DATE COMPLETED _____ / _____ / _____

PATIENT'S SIGNATURE MM DD YYYY

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Consent for Purposes of Treatment and Healthcare Operations

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare. I understand that diagnosis or treatment of me, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The above organization is not required to agree to the restrictions that I'm your request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent, in writing, at any time, except to the extent that the above organization has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the above organizations Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the above organization. The Notice of Privacy Practices are also provided at the above organization and on the website if applicable. This Notice of Privacy Practices also describes my rights and the above named organization's duties with respect to my protected health information.

The above named organization reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

Date _____/_____/_____
MM DD YYYY

_____
Description of Personal Representative's Authority

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Patient Acknowledgement of Financial Responsibility

1. (If applicable, Initial here _____) **Social Security Medicare (Non HMO)**
I, the undersigned, certify that the information given by me and applied on the TITLE XVIII of the Social Security act is correct. By initializing the above classification, and I acknowledge that I am not a member of the Medicare HMO. I further authorize any physician, affiliate, or staff to release to Social Security Administration, or it's intermediaries, any and all information needed to process this or any other Medicare related claim. I request and assign that payment of all authorized benefits be made on my behalf to the Broward Hand Center, Inc. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles, and co-insurance payments. In addition, subsequent rejection of Medicare claims, as a result of enrollment in a Medicare HMO, will constitute responsibility for payment on my part.

2. (If applicable, Initial here _____) **Medicaid**
I, the undersigned, by initialing the above classification, certify that I am a recipient of the Medicaid program. TITLE XIX.1 authorizes Broward Hand Center, Inc., to release any and all requested information concerning medical insurance, and financial records relating to my hospitalization and/or outpatient care to the State of Florida.

3. (If applicable, Initial here _____) **Commercial Insurance and Assignment**
By initialing the above classification, I hereby authorized, request and irrevocably assign payment directly to those organizations who provided services covering this period of treatment, and past and future treatment if related to the incident or condition giving rise to this admission, from all insurance carriers with whom I have coverage or from whom benefits are, or may become payable to me, including settlements on judgments flowing from the incident for which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me, but shall not exceed the regular charges for this and any other period of treatment. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments. It is further agreed that any credit balance relating from overpayment of insurance and other sources may be applied to any other accounts owed to said physician, medical group, by his/her family.

4. (If applicable, Initial here _____) **HMO/PPO/MEDIPASS MANAGED CARE PARTICIPATION**
By initialing the above classification, I the undersigned, understand that I am certifying that I'm a member of an HMO/PPO/MEDIPASS or other Managed Care Organization, and I have obtained required authorizations and referrals as mandated by my Managed Care Organization to receive care from this facility and its providers. I further acknowledge that if I choose to receive services at this facility without proper authorization from the Managed Care Organization; I will be fully responsible for payment of my bill. I realize that this it is my responsibility as the patient to know whether a service, procedure, and/or test, etc., is covered by my Managed Care Organizations. (As the patient, I may contact my Managed Care Organization to appeal their decisions not to authorize services.)

5. Guarantor Agreement
By signing this form as Patient/Parent/Guardian/Agent/or Guarantor, spouse or agent of the aforementioned parties, I hereby agree that any and all charges that arise within this treatment if related to the incident or condition giving rise to this admission or service, not covered by any insurance, program, sponsorship, or other third party coverage I may have, are due and payable by me at the time of discharge or discontinuation of treatment. I hereby acknowledge that the Broward Hand Center, Inc. has agreed to bill my insurance or other third party carrier and has agreed to do so as a courtesy and the Broward Hand Center, Inc. has the right to demand full payment from me at any time prior to full payment from any insurance carrier or third party payer unless it is contractually stated that I will not be billed. I hereby acknowledge that I have been told, prior to receiving treatment, that I may be billed by the Broward Hand Center, Inc.

I hereby acknowledge that I have read this form and understand its contents and agree to all of the provision herein.

_____ _____
Signature of Patient/Guardian/Authorized agent Witness

_____ DATE _____/_____/_____
Spouse/Guarantor Signature MM DD YYYY

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