Bloomfield
HAND SPECIALISTS

MEDICAL HISTORY

Today's Date: ____/____/____

PATIENT NAME (PLEASE PRINT)			BIRTH DATE			AGE	MALE	FEMALE
FIRST	LAST	M.I.	MM	DD	YYYY		☐	☐
PARENT/GUARDIAN NAME IF PATIENT IS A MINOR			HEIGHT			WEIGHT		
FIRST	LAST	M.I.						

ETHNICITY & RACE IS A FEDERAL REQUIREMENT MANDATED BY CMS-CENTERS FOR MEDICARE & MEDICAID SERVICES

ETHNICITY:
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO

RACE:
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ ASIAN
☐ BLACK/AFRICAN-AMERICAN
☐ NATIVE HAWIIAN OR PACIFIC ISLANDER
☐ WHITE

PREFERRED LANGUAGE: ☐ ENGLISH ☐ ESPAÑOL OTHER:

REFERRED BY:	PRIMARY CARE PHYSICIAN:	PREFERRED PHARMACY (PHONE):
NAME	NAME	PHARMACY NAME (###)-###-####

CHIEF COMPLAINT

Why are you seeing the doctor today?

Have you been to an Emergency Room or Urgent Care Center for this problem ? ☐ YES ☐ NO

If yes, which facility?

When did your symptoms start or injury occur?

What tests have been performed?
☐ Xray ☐ CT Scan ☐ MRI ☐ EMG ☐ Other:

What treatments have you tried:

Choose a number between 0 and 10 that best describes your pain:

No Pain	Mild		Moderate		Severe		Very Severe			Excruciating
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Is your complaint work related? ☐ YES ☐ NO

Is this automobile related? ☐ YES ☐ NO

PAST MEDICAL HISTORY

☐ None
☐ Asthma
☐ Cancer
☐ HIV or AIDS
☐ Blood Clots
☐ Rheumatoid Arthritis
☐ Other:
☐ High Blood Pressure
☐ Sleep Apnea
☐ Diabetes
☐ Ulcer or Acid Reflux
☐ Bleeding Problems
☐ Autoimmune Disease
☐ Heart Disease
☐ Seizure Disorder
☐ Hepatitis
☐ Thyroid Problems
☐ Psoriasis
☐ Anxiety or Depression

PAST SURGERIES: (Please list all previous surgeries and approximate dates)

ANESTHETIC

Have you ever had anesthesia? ☐ YES ☐ NO

If yes, have you had any reaction to local or general anesthetic? ☐ Y ☐ N

If yes, Please describe:

MEDICATIONS

Please list all current medications and dosages if known. Remember to include over the counter medications, herbal supplements, and prescription medicines.

☐ None

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ALLERGIES	SOCIAL HISTORY:	
Please list all known allergies and the type of reaction: ☐ None	Occupation: ☐ Student/Name of School:	MARITAL: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed CHILDREN?: ☐ Yes ☐ No LIVE ALONE?: ☐ Yes ☐ No EXERCISE: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
	Do you smoke? ☐ Yes ☐ No ☐ Quit If yes, ___ packs per day for ___ years If quit, when did you quit? _____	Do you drink alcohol? ☐ Yes ☐ No If yes, average drinks per week _____

FAMILY HISTORY: (PLEASE CHECK ALL THAT HAVE SIGNIFICANCE IN YOUR FAMILY'S HISTORY, NOT YOUR OWN HISTORY)

NONE: ☐	Arthritis	Diabetes	Heart disease	Stroke	Cancer	Other
FATHER	☐	☐	☐	☐	☐	☐
MOTHER	☐	☐	☐	☐	☐	☐
SIBLINGS	☐	☐	☐	☐	☐	☐

List family history of orthopedic problems:

REVIEW OF SYSTEMS: Check all symptoms that apply to you from each of the 14 categories.

CONSTITUTIONAL	☐ None	☐ Night sweats	☐ Fever/chills	☐ Unexpected weight gain ___lbs in the last year?	☐ Unexpected weight loss ___lbs in the last year?
EYES	☐ None	☐ Visual changes	☐ Glasses or Contacts		
EARS, NOSE, THROAT	☐ None	☐ Hearing problems	☐ Sore throat	☐ Cold	☐ Sinus allergies
CARDIOVASCULAR	☐ None	☐ Chest Pain	☐ Palpitations	☐ Leg swelling	☐ Calf cramps with walking
RESPIRATORY	☐ None	☐ Shortness of breath	☐ Wheezing	☐ Frequent cough	☐ Coughing up blood
GASTROINTESTINAL	☐ None	☐ Ulcer	☐ Bowel/bladder control	☐ Diarrhea	☐ Vomiting
GENITOURINARY	☐ None	☐ Incontinence	☐ Burning while urinating	☐ Blood in urine	☐ Kidney stones
MUSCULOSKELETAL	☐ None	☐ Back ache	☐ Joint stiffness	☐ Joint swelling	☐ Joint pain
INTEGUMENTARY	☐ None	☐ Rash	☐ Hair problem	☐ Nail problem	
NEUROLOGICAL	☐ None	☐ Headaches	☐ Memory loss	☐ Fainting	☐ Tingling and numbness
PSYCHIATRIC	☐ None	☐ Depression	☐ Nervousness	☐ Personality change	☐ Previous psychiatric care
ENDOCRINE	☐ None	☐ Excessive urination	☐ Excessive thirst	☐ Intolerance to heat/cold	
HEMATOLOGIC/ LYMPHATIC	☐ None	☐ Abnormal bleeding	☐ Anemia		
ALLERGIC/IMMUNOLOGIC	☐ None	☐ Immunization problems	☐ Allergy shots		

THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Patient Name (Please Print)	Guardian Name (Please Print)
Patient Signature: Date	Guardian Signature: Date
Physician Signature Date	

Bloomfield
HAND SPECIALISTS

FINANCIAL POLICY ACKNOWLEGDMENT

Thank you for choosing Bloomfield Hand Specialists as your medical provider. We are committed to you and the success of your treatment. We request you read and sign the following financial policy. Please feel free to ask any questions regarding our policy.

Insurance: We participate in most insurance plans. We will only accept assignment of benefits with insurance plans with which we participate. Please provide all your insurance information necessary for us to bill your insurance carrier. Any remaining balances (copayments, deductibles, or non-covered services) are your responsibility.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim.

Co-payments and Deductible: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Proof of Insurance: We must obtain a copy of your driver's license and current valid insurance information to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Non-Covered Services: Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay in full for these services at the time of your visit.

Referrals: If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If you are unable to obtain the referral by the time of your visit, you will be rescheduled. If you choose to keep the scheduled appointment without a referral, you will be responsible for full charges to be paid that day and also sign a waiver.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. Without the authorization, your appointment will be rescheduled until written authorization is obtained.

Methods of Payments: We accept payment by cash, check, VISA, MasterCard, and Discover.

Non-Payment: The balance on your statement is due and payable when the statement is issued. Any account with a balance which has not had a payment made monthly, may be charged a billing fee. Any account over 120 days old without payment arrangements or monthly payment activity may be turned over to a collection agency. Payment plans can be arranged in certain circumstances. Please discuss this with the Office Manager.

I have read and understand this financial policy:

PRINTED NAME:
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:
DATE:

Original: Patient
Copy: BHS

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HAND SPECIALISTS

NOTICE OF PRIVACY POLICY

This notice describes how Health Information about you may be used and how you can get access to this information. Please review it carefully. The Privacy of your Health Information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003 and will remain in effect until the law changes.

We reserve the right to change our policy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy policy, or for additional copies of this notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: we may use and disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use or disclose your health information to obtain payment for services we provide to you. HealthCare Operations: We may use and disclose your health information in connection with our health care operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your consent may also be required in order for this office to make uses and disclosure of your health information if required by Michigan Law.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of a family member (including identifying or locating) your personal representative or another person responsible for your care or your location, your general condition, or death. If you are present, then prior to the use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. Marketing Health Related Services:

We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law. Abuse or Neglect: We may disclose your health information when we are required to do so by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS:

Access: You have the right to look at copies of your health information. You may request that we provide you with copies of your health information. (There is a fee for this service.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make the request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice by e-mail you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS:

If you have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.