New England Hand Associates, PC

761 Worcester Road

Framingham, MA 01701

☐ **Louis M. Jurist, MD**
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☐ **Jeffrey F. Dietz, MD**

PLEASE PRINT CLEARLY

Patient Information

PATIENT NAME LAST	FIRST	INITIAL	SEX	DATE OF BIRTH

HOME ADDRESS	CITY	STATE	ZIP

HOME TELEPHONE	DAYTIME TELEPHONE	EMAIL

VNA/ NURSING HOME (*IF APPLICABLE*)	ADDRESS

Parent/Guardian Information (*IF PATIENT IS A MINOR*)

GUARANTOR NAME LAST	FIRST	INITIAL	SEX	DATE OF BIRTH

HOME ADDRESS (*IF DIFFERENT*)	CITY	STATE	ZIP

HOME TELEPHONE	DAYTIME TELEPHONE	EMAIL

Insurance Information (*PLEASE GIVE CARD(S) TO RECEPTIONIST FOR SCANNING*)

X **PRIMARY INSURANCE**	IDENTIFICATION / CLAIM NUMBER / GROUP #
ADDRESS	SUBSCRIBER NAME
ADDRESS	RELATIONSHIP TO PATIENT

CITY	STATE	ZIP	TELEPHONE

SECONDARY INSURANCE	IDENTIFICATION / CLAIM NUMBER / GROUP #
ADDRESS	SUBSCRIBER NAME
ADDRESS	RELATIONSHIP TO PATIENT

CITY	STATE	ZIP	TELEPHONE

Workers Comp Claim

PATIENT'S EMPLOYER	TELEPHONE

EMPLOYER'S ADDRESS	CITY	STATE	ZIP

ADJUSTER'S NAME / WC INSURANCE COMPANY	TELEPHONE	CLAIM / SOCIAL SECURITY NUMBER

PCP & Pharmacy

X PRIMARY CARE PHYSICIAN	TELEPHONE	GROUP / PRACTICE NAME

ADDRESS	CITY	STATE	ZIP

X LOCAL PHARMACY	PHARMACY'S ADDRESS

AUTHORIZATION TO PAY BENEFITS TO NEHA PHYSICIAN: I hereby authorize payment directly to the NEHA physician, named above, of medical/surgical benefits, if any, otherwise payable to me for their services.	X PATIENT SIGNATURE (PARENT OR GUARDIAN IF PAITENT IS A MINOR)	X DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the NEHA physician, named above, to release any information acquired in the course of my examination or treatment to legal entities authorized to receive Protected Health Information [PHI]under HIPAA.	X PATIENT SIGNATURE (PARENT OR GUARDIAN IF PAITENT IS A MINOR)	X DATE

New England Hand Associates, PC

Personal Medical History

Name: _____

Date of Birth: ____/____/_____ **Dominant Hand**: ☐ Right ☐ Left

Referred by: _____

Ht: _____ **ft** _____ **in** **Wt**: _____ **lbs** **BP**: _____ /_____

Gender: ☐ Male ☐ Female

Date of Injury or Onset of Problem (approx. date):: _____/_____/_____

Work Related?: ☐ Yes ☐ No **Auto Accident Related?**: ☐ Yes ☐ No

Is there a legal claim involved?: ☐ Yes ☐ No ☐ Pending

If yes, Attorney: _____

Have you seen another physician for today's problem? ☐ Yes ☐ No

Who / Where? _____

Were you seen in an emergency room? ☐ Yes ☐ No

If Yes, Where / Date(s) Seen: _____

Tests Ordered: ☐ MRI ☐ CT Scan ☐ X-Ray ☐ EMG ☐ Other (list):

_____

GOVERNMENT REQUIRED INFORMATION:

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Multi-Racial ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Description of Problem

				Fingers				
Shoulder	**Elbow**	**Wrist**	**Hand**	**Thumb**	**Index**	**Long**	**Ring**	**Small**
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ L

Briefly describe your problem – what is injured / hurts / is bothering you? How did this happen?

_____

What type of pain are you having? ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning ☐ none

Do you have any of the following? ☐ swelling ☐ bruising ☐ numbness ☐ tingling ☐ weakness ☐ locking/catching

The pain is: ☐ constant ☐ comes and goes (intermittent) ☐ night-time only ☐ absent

What makes your symptoms worse? ☐ lifting ☐ exercise ☐ twisting ☐ work ☐ weather ☐ other (explain below):

What makes your symptoms better? ☐ rest ☐ ice ☐ compression ☐ elevation ☐ medication ☐ other (explain below):

_____

Medications/Tests/Vaccines/Social History/Allergies

List <u>all</u> medications you currently take, including non-prescription drugs:	Dosage:	Frequency of Use:	Reason for Taking:

Tests & Vaccines: Required Public Health Screening

Test/Vaccine	Date Rec'd	Results +/ -	Not Done [X]
Influenza [Flu]			
Pneumonia			
Mamogram			
PAP Test			
Colonoscopy			

Do you smoke?: ☐ Yes ☐ No

Packs/day: ☐ 1/4 ☐ 1/2 ☐ 1 ☐ 1-2+

Previously smoked: ☐ Yes ☐ No

How long since you quit?: _____

Do you drink alcohol?: ☐ Yes ☐ No

Type: ☐ Beer ☐ Wine ☐ Mixed drinks

No. of drinks: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Frequency: ☐ day ☐ week ☐ month

Do you chew tobacco?: ☐ Yes ☐ No

Do you use any recreational drugs?:

☐ Yes ☐ No

Specify: _____

_____

Problems w/ anesthesia? ☐ Yes ☐ No

Problems w/ adhesives? ☐ Yes ☐ No

Latex allergies? ☐ Yes ☐ No

History of MRSA? ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No **If yes, list**:

Allergies to Medicine:_____

_____

_____

_____

Other Allergies:_____

_____

_____

_____

Medical History *(check all that apply)*

☐ Alzheimer's Disease	☐ Gout	☐ Inflammatory bowel disease (i.e., Crohn's Disease, ulcerative colitis)	☐ Osteoarthritis
☐ Bleeding problems (i.e., anemia, blood clots, DVTs)	☐ Heart disease - ***please specify below***	☐ Kidney disease	☐ Pacemaker implanted
☐ Cancer - ***please specify type below***	☐ Hepatitis B	☐ Liver disease	☐ Pneumonia
☐ Digestive disorders (i.e., colitis, diverticulitis, gastritis, GERD, hiatal hernia, ulcers)	☐ Hepatitis C	☐ Lung infection/disease (i.e., Emphysema, asthma, COPD)	☐ Pregnancy
☐ Depression	☐ High blood pressure	☐ Lyme Disease	☐ Psychiatric illness-***specify below***
☐ Diabetes	☐ High cholesterol	☐ Neurological disorders (i.e., ALS, Multiple Sclerosis, Muscular Dystrophy)	☐ Renal failure
☐ Fibromyalgia	☐ HIV/AIDS	☐ Obesity	☐ Seizures
☐ Gallstones	☐ Hyperthyroid disease	☐ Osteoporosis	☐ Sleep apnea ☐ use C-PAP
☐ Glaucoma	☐ Hypothyroid disease		☐ Strokes/CVA
	☐ Inflammatory arthritis (i.e., Rheumatoid Arthritis, Lupus)		☐ Take steroid medication
	☐ Irregular heartbeat		☐ Vertigo
			☐ **NONE**

Please specify from above or list other conditions not shown:

_____

Surgical History – list (a) all surgeries within past 5 years, and (b) all major surgeries, including surgery from fingertips to shoulder, at any time in the past

Type of surgery/hospitalization:	**Doctor:**	**Hospital:**	**Approximate date:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical History *(check problem and who was diagnosed)*

Family Member	**Living**	**Dead**	**Health Issue(s), if any:**
☐ Father	☐	☐	_____
☐ Mother	☐	☐	_____
☐ Sibling _____	☐	☐	_____
☐ Sibling _____	☐	☐	_____
☐ Sibling _____	☐	☐	_____

Review of Systems – Are you currently experiencing any of the symptoms below? If no, mark "None"

General	☐ Fever	☐ Fatigue/weakness	☐ Chills	☐ Sweats
Eyes	☐ Blurred/double vision	☐ Vision loss	☐ Cataracts	☐ Contact lenses
Ear/Nose/Throat	☐ Trouble swallowing	☐ Hoarseness	☐ Hearing loss	☐ Ringing in ears
Cardiovascular	☐ Chest pain	☐ Palpitations	☐ Fainting spells	☐ Claudication
Respiratory	☐ Shortness of breath	☐ Chronic cough	☐ Wheezing	
Gastrointestinal	☐ Heartburn/ulcers	☐ Nausea/vomiting	☐ Blood in stool	
Urinary	☐ Trouble urinating	☐ Frequent urination	☐ Blood in urine	☐ Kidney stones
Musculoskeletal	☐ Joint pain/swelling	☐ Stiffness	☐ Muscle cramps	☐ Neck pain
Skin	☐ Frequent rashes	☐ Skin ulcers	☐ Skin infections	☐ Itching
Neurological	☐ Headaches	☐ Dizziness	☐ Numbness	☐ Muscle weakness
Psychological	☐ Anxiety	☐ Drug/alcohol addiction	☐ Sleep disorder	
Endocrine	☐ Heat/cold intolerance	☐ Unusual weight gain	☐ Unusual weight loss	☐ **NONE**
Blood/Lymphatic	☐ Bleed easily	☐ Bruise easily	☐ Enlarged lymph nodes	

X **Signature:** _____ ***X*** **Date:** _____

Revised on 10/18/2015

New England Hand Associates, PC

The physicians and staff of New England Hand Associates, PC (NEHA) welcome you as a patient. We are pleased you have chosen us for your medical care. Please review the following notices and agreements, and sign and date below where indicated.

NOTICE OF PRIVACY PRACTICES

NEHA is committed to protecting the privacy and confidentiality of your health information. Through your signature below, you acknowledge that you were made aware of and offered a copy of our Notice of Privacy Practices. Additionally, you consent to NEHA's use and disclosure of your personal health information for treatment, billing, and health care operations. You also authorize us to obtain your medication history from pharmacies or Pharmacy Benefit Managers. Please note on your Patient Information Sheet if you authorize us to discuss your appointments or health information with anyone else.

IDENTITY THEFT COMPLIANCE

It is our policy to verify the identity of each patient at time of registration. NEHA will, to the extent feasible, request documentation of each patient's identity, residential address, and health insurance coverage at registration as part of our practice's Identity Theft Prevention Program.

Photo ID Checked: ☐ Driver's license ☐ Government-issued ID ☐ Utility bill ☐ Other (please indicate)

Health Insurance Card: ☐ Examined & cross-checked with above ID **Relationship to Patient:** _____

If the patient is a minor, patient's parent, legal representative or guardian should bring the information listed above.

FINANCIAL AGREEMENT

Please be advised that NEHA does not participate in all insurance plans and that in some cases certain services are not covered by insurance. Through your signature below, you agree to allow payment for covered and authorized insurance benefits to be made on your behalf to NEHA. You understand that your consent/authorization does not guarantee payment or reimbursement or release you from your obligation and responsibility to pay all outstanding charges not covered by insurance including, but not limited to, co-payments, co-insurance, deductibles, usual and customary schedules, maximum allowances/limits or non-covered services amounts.

If services are not covered by your insurance, our office policy is to receive payment at the time services are rendered. We encourage you to make certain that you fully understand your financial obligations, since you are ultimately responsible for the cost of all services you receive. We are able to provide a general explanation about insurance coverage for the services provided by our practice, but only your insurance company has specific information and details about how your plan works. We strongly recommend that you contact your plan for details about your coverage. If you, and not your insurance company, are responsible for payment of your care, please be advised that we may charge interest and collection fees, including attorneys' fees, with respect to any past due accounts or returned payments.
If your health insurance plan requires you to obtain authorization or a referral prior to treatment in our office, you agree to obtain such authorization or referral in a timely fashion. If you have not obtained such authorization or approval and your health plan subsequently denies payment, you will be required to pay for the services we render.

PARTNERS IN YOUR CARE

In the course of your evaluation, management and ongoing treatment, your NEHA physician may suggest that you have certain tests performed, that you be evaluated by a physician of a different specialty, or that you return to this office on a future date for re-evaluation and/or treatment. Please keep all scheduled appointments and associated commitments.

The field of medicine, especially Orthopedic Surgery, often involves problems which, if not properly disclosed or addressed, can have long-term health consequences or become life threatening. Thus, if, for some reason, you cannot proceed with your agreed-upon plan of care, please let us know as soon as possible. As partners in your health care, we are concerned about the possible consequences to your care, treatment, or recovery of not fully disclosing important information to your NEHA provider or not following through with recommended testing or scheduled appointments.

Patient/Guarantor/Guardian:

(PRINT NAME) ***X*** _____ (SIGN) ***X*** _____ DATE: ***X*** _____

Your signature above indicates that you have read all of the above statements and agree to accept the terms and conditions of being a patient of New England Hand Associates, PC

NEHA
New England Hand Associates

OCCUPATIONAL THERAPY SERVICES

CUSTOM ORTHOSIS

Oftentimes an orthosis/splint is recommended by the Hand Surgeons here at New England Hand Associates in order to immobilize a joint or joints. It can be an "off-the-shelf" splint that is prefabricated and typically comes in a box. It can also be a custom made orthosis/splint that is made especially for you and your specific condition by one of our licensed occupational therapy. This might be recommended by the Physician over a cast, based on the type and location of your injury. The custom orthosis helps maintain bone alignment and protects the injured area, just like a cast. The difference is that the orthosis can be removed for hygiene purposes and possibly exercise if prescribed/instructed by the Physician and/or Hand Therapist. These orthosis, whether off-the-shelf or custom, are often classified as durable medical equipment (DME) by insurance companies.

INSURANCE COVERAGE FOR ORTHOSIS

Insurance companies are continuously changing what they will or will not allow and, therefore, reimburse for medical treatment and/or durable medical equipment (DME). This includes both off-the-shelf splints and custom orthosis fabricated by the therapist. Also, there are literally thousands and thousands of health insurance plans that are offered by these companies, which makes it nearly impossible for us to keep up with everyone's individual plan coverage and deductible policies. We will do what we can to help you navigate through this complicated process and to share with you what our experience has been with various insurance companies. However, we are simply not in a position of knowing or being able to guarantee exactly what you will be financially responsible for. Therefore it is important for you to know that **you are responsible for knowing your insurance, what is covered and what your financial responsibility may be**.

If you have any questions or concerns about your financial responsibility for any service or product that we may offer you, you should call your insurance company to clarify your benefits, coverage and any out-of-pocket expenses you might have prior to receiving those services/products. As always, you can discuss with the physician or therapist other options that might be available until you have full clarification from your insurance carrier.

☒ I understand and acknowledge that at this time there may be a copay/co-insurance/deductible for the orthosis/treatment prescribed by the physician and that I accept full responsibility for payment of any expense which are deemed the patient's responsibility.

☒ I understand that I am responsible for payment of services rendered should they deny authorization or if it is not a covered service of my particular insurance plan.

Patient Name: _____ Signature: _____ Date: _____

Guardian Name: _____ Signature: _____ Date: _____

(If patient under 18 years old)