Cy-Fair Hand & Wrist Surgical Associates, PA

WELCOME TO THE PRACTICE

Pt. Last Name _____ **First Name** _____ **MI** _____

Gender (M or F) _____ Age _____ **Today's Date** _____

I am : Right Handed Left Handed **Injured arm/hand:** Right Left

Occupation _____ **Employer** _____

Referring Physician _____ **Phone #** _____

Date of Injury _____ **Reason for visit today** _____

_____

What makes it better ? _____

What makes it worse ? _____

_____

Height: _____

Most recent Weight: _____

Past Medical History : Please fill in the ovals completely for **any** of the conditions that you have/had:

0 Insulin Dependent Diabetes	0 High Blood Pressure	0 Heart Disease
0 Non-insulin Dependent Diabetes	0 Blood Clots	0 Heart Attacks
0 Hypothyroidism	0 Bleeding Disorder	0 Lung Disease
0 Reaction to Anesthesia	0 Kidney Disease	0 Hepatitis
0 HIV/AIDS	0 Peptic Ulcer	0 Liver Disease
0 Rheumatoid Arthritis	0 Hyperthyroidism	0 Drug Abuse
0 Alcoholism	0 Asthma	0 Psychiatric disorder: what type? _____
0 Cancer: What type? _____		Are you pregnant? 0 Yes 0 No

0 Any other medical problems? _____

Social History : Please fill in the ovals completely for **any** of the conditions that you have/had:

Do you smoke ?	0 Yes 0 No	If yes, how much? _____
Do you drink alcohol ?	0 Yes 0 No	If yes, how much? _____
Do you use recreational drugs?	0 Yes 0 No	If yes, what kind? _____
Are you currently working?	0 Yes 0 No	
Are you on any restrictions?	0 Yes 0 No	If yes, please describe?

_____

Past Surgical History : Please list each Surgery (Procedure and Year) that you have had :

_____

_____

Pt. Last Name _____ **First Name** _____ **MI** _____

Allergies : Please list any medications that you are allergic to and what happens when you take them ?

_____

_____

_____

Medications : Please list ALL Medications that you take (including Aspirin, Motrin, Supplements, etc.)

_____

_____

_____

Review of Systems : Please fill in the oval completely for **any** of the conditions that you have/had:

0 Fever 0 Dizziness 0 Fingertip cold intolerance 0 Rash

0 Depression 0 Fingertip ulcers 0 Blood in stool 0 Productive cough

0 Shortness of breath 0 Difficulty urinating 0 Constipation 0 Weight loss

0 Tingling/numbness in feet or hands 0 Chest pain 0 Diarrhea 0 Weight gain

0 "Just don't feel well" 0 Joint aches: Which joints? _____

Family History : Please fill the oval completely for **any** medical problems in your immediate family (Mother, Father, Sister, Brother):

0 Reaction to anesthesia 0 Hypertension 0 Rheumatoid Arthritis

0 Bleeding problems 0 Heart problems 0 Diabetes

0 HIV/ AIDS 0 Lung Disease 0 Cancer : What type?_____

0 Other diseases that run in the family ?

_____

_____

As a Medicare provider, we are required to ask the following questions. You may opt not to answer:

Please circle one that applies to your Race:

White Hispanic African American/ Black American Indian/ Native Alaskan Asian

Pacific Islander/Nativo Hawaian Do Not Wish to Answer Other _____

Please select one Ethnicity that applies to you:

Hispanic/Latino Non-Hispanic/Non-Latino Do Not Wish to Answer

Primary Language:_____

Cy-Fair Hand & Wrist Surgical Associates, P.A.
Office & HIPPA (Privacy) Policies

We reserve the right to charge a $25 fee for all missed appointments or appointment cancellations made less than 24 hours of the scheduled appointment.

We will charge $50 fee for any paperwork needing to be filled out by the doctor outside of basic work/school excuse notes, Worker's Compensation (DWC-73) forms, or FMLA paperwork. This includes but is not limited to: Long Term Disability, Short Term Disability, AFLAC or Colonial paperwork.

As per Texas Law, under Medical Records Confidentiality, Section 26: Texas Medical Board Rules; Medical Record Release and Charges, we charge a minimum fee of $25 for the first 25 pages and $0.50 per page for every copy thereafter for any medical record copies for personal use. We will mail or fax copies to another physician with a signed release free of charge within 15 business days of receipt of request.

ALL PATIENT DEDUCTIBLES AND CO-INSURANCE FEES MUST BE PAID PRIOR TO ANY SCHEDULED OFFICE VISIT OR SURGERY, NON-PAYMENT WILL RESULT IN CANCELLATION OF YOUR APPOINTMENT OR SURGERY. WORKER'S COMPENSATION CLAIMS/BILLS THAT ARE DENIED FOR ANY REASON WILL BECOME THE RESPONSIBILITY OF THE PATIENT.

I have read and I am aware of the above policies. PATIENT INITIALS_____

PRIVACY (HIPPA) POLICY

May we communicate with you via e-mail? YES NO If yes, list e-mail address:_____

May we discuss your case with your employer or personal/Worker's Comp Insurance company? YES NO

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment. Please let us know with whom we may share information.

_____ _____
Name Relationship

_____ _____
Name Relationship

By signing below, I authorize the persons listed above to receive my protected health information. I understand that I may revoke this authorization at any time. My revocation must be in writing to Cy-Fair Hand & Wrist Surgical Associates, P.A. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal and state privacy protection regulations).

Please see the laminated pages on this clipboard. My initials indicate that I have been given the opportunity to review the office's Privacy Policy and Patient Bill of Rights. I am aware that this information is available to review in the office at anytime.

Privacy Policy PATIENT INITIALS_____

Patient Bill of Rights PATIENT INITIALS_____

Notice of Physician Financial Ownership PATIENT INITIALS_____

_____
Print Name

_____ _____
Patient Signature or Guardian Date

Patient Bill of Rights

This Facility adopts and affirms as policy the following rights of patient/clients who receive services from our facility. The facility will provide the patient or the patient's representative verbal and written notice of such rights in advance of the date of the procedure in accordance with 42 C.F.R. § 416.50, and these patient rights will be posted within the facility in the facility's waiting room(s).

The patient rights are as follows:

- Treatment without discrimination as to age, race, color, religion, sex, national origin, political belief, or handicap. It is our intention to treat each patient as a unique individual in a manner that recognizes their basic human rights.
- Considerate and respectful care including consideration of psychosocial, spiritual, and cultural variables that influence the perceptions of illness.
- Receive, upon request, the names of physicians directly participating in your care and of all personnel participating in your care.
- Obtain from the person responsible for your health care complete and current information concerning your diagnosis, treatment, and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information shall be made available to an appropriate person in your behalf.
- Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations. This information shall include as a minimum an explanation of the specific procedure or treatment itself, its value and significant risks, and an explanation of other appropriate treatment methods, if any.
- The patient may elect to refuse treatment. In this event, the patient must be informed of the medical consequences of this action. In the case of a patient who is mentally incapable of making a rational decision, approval will be obtained from the guardian, next-of-kin, or other person legally entitled to give such approval. The facility will make every effort to inform the patient of alternative facilities for treatment if we are unable to provide the necessary treatment.
- The facility will provide the patient or patient representative with the facilities policies and description of the State health and safety laws on advance directives, and upon request, refer you to resources for general information on how to formulate an advance directive, including where to obtain the official State advance directive form, and appointing a surrogate to make health care decisions on your behalf, to the extent permitted by law. Access to health care at this facility will not be conditioned upon the existence of an advance directive.
- Privacy to the extent consistent with adequate medical care. Case discussions, consultation, examination and treatment are confidential and should be conducted discreetly.
- Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party payment contract.
- A reasonable response to your request for services customarily rendered by the facility, and consistent with your treatment.
- Expect reasonable continuity of care and to be informed, by the person responsible for your health care, of possible continuing health care requirements following discharge, if any.
- The identity, upon request, of all health care personnel and health care institutions authorized to assist in your treatment.
- Refuse to participate in research or be advised if your personal physician and/or facility proposes to engage in or perform human experimentation affecting his/her care or treatment. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services
- Upon patient request, examine and receive a detailed explanation of your bill including an itemized bill for services received, regardless of sources of payment.
- Know the facility's rules and regulations that apply to your conduct as a patient.
- Be advised of the facility grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge date is premature. Notification of the grievance process includes: who to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Complaint or criticisms will not serve to compromise future access to care at this facility. Staff will gladly advise you of procedures for registering complaints or to voice grievances including but not limited to grievances regarding treatment or care that is (or fails to be) furnished.
- Access and copy information in the medical record at any time during or after the course of treatment. If patient is incompetent, the record will be made available to his/her guardian.
- Expect to be cared for in a safe setting regarding: patient environmental safety, infection control, security and freedom from abuse or harassment.
- Receive care, free of restraints unless medically reasonable issues have been accessed and pose a greater health risk without restraints.
- Participate in the development, implementation and revision of his/her care plan.

Complaints

- Complaints may be directed to the following: Cy-Fair Surgery Center Contact: **Sonja Christmas or Cindy Kelley at 11250 Fallbrook Drive Houston, Tx. 77065 Phone 281-955-7194.** Dr. Fiore's Office Contact: **Cecilia Fiore: Phone 281-970-8002**
- Complaints may be directed to the following State Agency: Texas Department of Health Hotline at 1-888-973-0022
- Web site for the Medicare Beneficiary Ombudsman: www.medicare.gov or 1-800-633-4227 or www.cms.hhs.gov/center/ombudsman

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can obtain this information. PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments. Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying services. An example would be your health plan may request and receive information on dates of service, services provided and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the daily activities of Cy-Fair Hand and Wrist.

As an example, information on the services you received may be used to support financial reporting, projections, and steps for evaluating and promoting quality care.

Legal. Your health information may be disclosed to public health agencies as required by law. An example would be if we are required to report some communicable diseases to the state's public health department.

Other uses and disclosures requiring authorization. Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information

Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

Cy-Fair Hand and Wrist Duties

We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Revising Privacy Practices

We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

For more information about HIPAA:

US Department of Health and Human Services
202-619-0257
Toll Free: 1-877-696-6775

Cy-Fair Hand & Wrist Surgical Associates, P.A.
Nicholas A. Fiore II, M.D., F.A.C.S.
11307 FM 1960 West, Suite 270 Houston, Texas 77065
9180 Katy Road, Suite 202 Houston, Texas 77055
www.handsurghouston.com
Phone: (281) 970-8002 Fax (281) 970-8770

NOTICE TO PATIENTS: Physician Financial Ownership

To Our Patients:

We are required by Federal law to notify you when a physician holds financial interest or ownership in a facility. We are required by 42 C.F.R. § 416.50 to disclose this financial interest or ownership in writing and in advance of the date of the procedure you are scheduled to receive at the facility.

Dr. Nicholas Fiore holds financial interest in the following facility:

NORTHWEST SURGERY CENTER
5215 HOLLISTER STREET
HOUSTON, TEXAS 77040
(713) 462-3194

Please feel free to contact the front desk if you would like a hard copy of this notice.

Sincerely,

Cy-Fair Hand & Wrist Surgical Associates, P.A.