THE HAND AND WRIST INSTITUTE

Welcome
Please take a few minutes to answer the following questions so that we may better assist you with your healthcare needs.

PATIENT INFORMATION **Date: _____**

Patient:

_____

Last Name ***First Name*** ***Middle***

Address:

_____

_____

City ***State*** ***Zip***

Birth Date: _____ Patient SS#: _____ - _____ - _____

Employer: _____ Business Phone: (_____) _____ - _____

Business Address: _____ Occupation: _____

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home: (_____) _____ - _____Cell: (_____) _____ - _____

Email:

_____

Best time and place to reach you?

_____

Pharmacy information:

_____

In case of emergency, who should we contact?

Name: _____ Relationship: _____

Home: (_____) _____ - _____ Work: (_____) _____ - _____

O| 817.382.6789 **F|** 817.527.8557
510 E. SOUTHLAKE BLVD. SUITE 140 – SOUTHLAKE, TX 76092
www.handandwristinstitute.com

THE HAND AND WRIST INSTITUTE

Patient Medical History

Patient Name: _____ **Birth Date:** _____ **Sex: M F**

Today's Date: _____ **Date of Injury:** _____ **Are You: Right-handed Left-handed**

Primary Care Physician: _____ **Phone: (_____) _____ - _____**

Is this work related? Yes No

Was it reported? Yes No

Were you sent to our office by a physician? Yes, No If so, please provide:

Requesting Physicians' Name: _____ **Phone: (_____) _____ - _____**

Physician's Address: _____ **City/State:** _____

History of Present Illness: **Problem:** **Right Extremity** **Left Extremity**

Ht: _____'_____" Wt.: _____lbs. Age: _____

Location: _____ **Quality:** _____
(Where is the pain/problem? Does it travel to other areas?) **(Is the pain dull, throbbing, and sharp? If lump, is it warm, tender, red?)**

Severity: _____ **Duration:** _____
(How severe is the pain on a scale of 1-5 with 5 being most severe?) **(How long have you had this pain/problem? When did it start?)**

Timing: _____ **Context:** _____
(Does the pain/problem occur at a specific time? Is it rare, intermittent, constant?) **(What were you doing at the onset of this pain/problem?)**

Associated Signs/Symptoms: _____
What other associated problems are you having (numbness, bladder or bowel complaints, abnormal sounds- Cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain)?

Modifying factors: _____
What makes the pain/problem worse or better (activities)?

Have you seen any other physicians regarding this condition prior to coming to our office? Yes No

Doctor	When	Tests	Results	Treatment

History of Present Illness:

Have you ever experienced any injury or symptoms regarding this body part? Yes No

If so, please provide details:

_____

_____

O| 817.382.6789 **F|** 817.527.8557
510 E. SOUTHLAKE BLVD. SUITE 140 – SOUTHLAKE, TX 76092
www.handandwristinstitute.com

THE HAND AND WRIST INSTITUTE

Which activities are you unable to perform due to your pain? _____

_____

Past Medical History: Have you ever had any of the following? Please check all pertinent boxes

Aids or HIV+	**Bronchitis**	**Hepatitis**	**Mumps**	**Thyroid Disease**
Anemia	**Chicken Pox**	**High Blood Pressure**	**Pneumonia**	**Tuberculosis**
Arthritis	**Diabetes**	**Infectious Mono**	**Polio**	**Ulcer**
Asthma	**Diphtheria**	**Kidney Disease**	**Rheumatic Fever**	**Venereal Disease**
Back Trouble	**Epilepsy**	**Low Blood Pressure**	**Scarlet Fever**	**Whooping Cough**
Bladder Infection	**Glaucoma**	**Measles**	**Sleep Apnea**	**Other (Please List)**
Bleeding Tendency	**Heart Disease**	**Migraine Headaches**	**Smallpox**	
Blood Transfusions	**Hemorrhoids**	**Mitral Valve Prolapse**	**Stroke**	

Medications: Include non-prescription & herbal supplements

Drug Name	**Dosage**	**Frequency**

Allergies:

Medication	**Reaction**	
Tape Allergy	**Yes**	**No**
Latex Allergy	**Yes**	**No**

Past Surgical/Hospitalization History:

Date	**Surgery/Illness**	**Doctor**	**Hospital, City, State**

O| 817.382.6789 **F|** 817.527.8557
510 E. SOUTHLAKE BLVD. SUITE 140 – SOUTHLAKE, TX 76092
www.handandwristinstitute.com

THE HAND AND WRIST INSTITUTE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____ **Date of Birth** _____

1. I acknowledge that The Hand and Wrist Institute will disclose my protected health information to a family member, other relative, close friend, or any other person I identify that directly relates to that person's involvement in my care. _____ (initial)

Person(s) _____ _____
(Relationship) **(Relationship)**

OR

1. I object to the disclosure of my protected health information to a family member, other relative, close friend, or any other person. _____(initial)
2. I acknowledge that The Hand and Wrist Institute may communicate with me via US mail, home phone number, or cell phone number. _____ (initial)
3. I request for an alternative method of communication such as alternative address or work phone number. _____ (initial)

Alternative method: _____

_____ _____
Patient Signature **Date**

_____ _____
Personal Representative Signature (if applicable) **Relationship to Patient**

O| 817.382.6789 **F|** 817.527.8557
510 E. SOUTHLAKE BLVD. SUITE 140 – SOUTHLAKE, TX 76092
www.handandwristinstitute.com

THE HAND AND WRIST INSTITUTE

Forms:
I understand that there is a charge of $25.00 for any forms I may need the doctor to fill out and or update for me. All forms will be processed in 7-10 business days.

No Show Policy:
There will be a charge of $40.00 for all missed appointments if they are not canceled or rescheduled at least 24 hours in advance. In case of surgery, the notice period is 72 hours, and the fee is $250.00.

Date: _____ **Signature:** _____

Assignment of Medical Benefits:
I authorize payment of medical benefits to be paid directly to the above identified physicians for professional services provided. I understand that I am responsible for any deductible, co-insurance, or co-payment according to the terms of my insurance plan. If this is a motor vehicle accident for a third-party liability, I, as the patient, am responsible for all charges not paid by my insurance company. I acknowledge that this office does not bill third-party payers.

Date: _____ **Signature:** _____

I certify that the injury for which I am being treated is not the result of motor vehicle accident or personal injury and that there is no litigation pending or in process regarding this injury.

Date: _____ **Signature:** _____

PLEASE NOTE

Due to the nature of the Doctor's schedule, and in order not to inconvenience other patients, you will be permitted to ten-minute grace period. If you are (or will be) more than ten minutes late to your appointment, please call the office to reschedule.

Surgery Candidates:
Please be informed that for any surgical procedure there are three entities that will bill your insurance:

- The surgeon (Dr. Knight)
- The surgery facility
- The anesthesiologist

We are only able to assist you with charges issuing directly from Dr. Knight.

Date: _____ **Signature:** _____

In Addition:

Dr. Knight performs all surgeries at an ambulatory surgery center, Legent Surgical Hospital in Plano & Medical City Argyle.

O| 817.382.6789 **F|** 817.527.8557
510 E. SOUTHLAKE BLVD. SUITE 140 – SOUTHLAKE, TX 76092
www.handandwristinstitute.com

THE HAND AND WRIST INSTITUTE

Authorization for Use or Disclosure of Protected Health Information

Name: _____ DOB: _____

Please ONLY fill out name dob and signature, we will fill out the rest if needed when requesting any previous records.

I hereby authorize _____to use or disclose my protected health information as indicated below to:

Name: ____The Hand and Wrist Institute_____
Phone number: _____817-382-6789_____ Fax: _____817-527-8557_____
Address: ____510 E Southlake Blvd Suite 140_____ City: _____Southlake_____
State: _____TX_____ Zip Code: _____76092_____

Information to be released:

From & Dates: _____

_____ Copy of complete records

_____ Information related to HIV testing results

_____History and Physical/Consultation reports

_____ Laboratory, X rays, PFT, Echo, Angio, OP reports

_____ Other

I understand that this health information includes HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am specifically authorizing the release of information relating to:

Substance Abuse (including alcohol/drug abuse
Mental Health
Psychotherapy Notes
HIV related information (including AIDS related testing)

_____ _____
Signature of Patient or Legal Guardian Date

Purpose of Disclosure:

____ Changing Physician ____ Second Opinion
____ Continuing Care ____ Legal
____ At my (patient) request ____ Insurance
____ Worker's Compensation ____ School
Other: _____

1. I understand that this authorization will expire two years from last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer at the address indicated below in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form
5. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature: _____Relationship: _____ Date: _____
Patient or representative

Email authorization disclosure

Federal law prohibits this practice from sending you texts or email which are unencrypted or "unsecure". However, many patients find it convenient to communicate with our office by traditional text and or email. Those mores of communication are generally not considered "secure". Some patients appreciate the tradeoff between ease of use /convenience and security. We want to accommodate your preferences. If you would like to communicate with us by "unsecure" text or email, please confirm below by providing your authorization. We will keep your preferences in force with no current expiration date until we learn otherwise. Obviously, you can change your mind at any point down the road. Just let us know in writing so we can stay updated with your preference(s). If messages are sent through such channels, they may no longer be protected by HIPAA. Finally, whether you decide to use email or text messaging, your choice will have no impact on our decision to treat you. We are here for you.

I authorize for the practice to communicate with me by "unsecure" email; that email addresses being:

Email address:_____

Signature/Date:_____