New York Hand Surgery
Hand • Wrist • Elbow • Microsurgery

Vipul Patel, MD Phay Huynh, PA-C
Andrew Yang, MD Timothy Godfrey, PC-A

New York Hand Surgery
New York Hand Surgery of Queens
www.handsurgeon.com
Ph. 718-369-4263 Fax. 718-369-4265 Text. 917-473-9890
Brooklyn Office : 330 9th street Brooklyn, NY 11215
Queens Office : 54-07 Roosevelt Avenue Woodside, NY 11377

Date : _____

Patient Name: _____ **DOB:** _____ **Age:** ___ **Sex:** M / F

Dominant hand: **Side of injury:**

Are you taking any medication? ○ Yes ○ No If yes, please List: _____

_____

List allergies to medication: _____

Reason for visit today _____

Have you been treated by another physician for this problem? Yes No

If yes, by whom? _____

PAST MEDICAL HISTORY: Do you now have or have you ever had any of the following:

1. Diabetes	○ Yes	○ No	7. Pneumonia	○ Yes	○ No
2. Heart Attack	○ Yes	○ No	8. Cancer	○ Yes	○ No
3. High Blood Pressure	○ Yes	○ No	9. Hepatitis	○ Yes	○ No
4. Tuberculosis	○ Yes	○ No	10. Ulcers	○ Yes	○ No
5. Asthma/Emphysema	○ Yes	○ No	11. Thyroid Disease	○ Yes	○ No
6. Lyme Disease	○ Yes	○ No	12. Stroke	○ Yes	○ No
			13. Blood Clots	○ Yes	○ No

PAST SURGERIES:

1. Type_____Year_____Hospital_____
2. Type_____Year_____Hospital_____
3. Type_____Year_____Hospital_____
4. Type_____Year_____Hospital_____
5. Type_____Year_____Hospital_____

SOCIAL HSTORY

Do you drink alcohol? ○ Yes ○ No If yes, how much? _____

Do you smoke now: ○ Yes ○ No If yes, how many packs per day? _____

Have you ever been a drug user? ○ Yes ○ No

Do you drink coffee? ○ Yes ○ No if yes, how much cups per day? _____

FAMILY HISTORY:	Alive/Dead	cause of Death	age
Father:	_____	_____	_____
Mother:	_____	_____	_____

1. Heart Disease	○ Yes ○ No	5: Thyroid disease	○ Yes ○ No
2. High Blood Pressure	○ Yes ○ No	6: Cancer	○ Yes ○ No
3. Diabetes	○ Yes ○ No	Location: _____	
4. Strokes	○ Yes ○ No	7: Other Disease_____	

REVIEW OF BODY SYSTEMS: Do you now have or have you ever had any of the following?

1. Notable weight change	○ Yes	○ No	10. Gallbladder Disease	○ Yes	○ No
2. Frequent Headaches	○ Yes	○ No	11. Bladder Infections	○ Yes	○ No
3. Excessive Thirst	○ Yes	○ No	12. Blood in Urine	○ Yes	○ No
4. Chest Pain	○ Yes	○ No	13. Kidney Stones	○ Yes	○ No
5. Palpations	○ Yes	○ No	14. Swollen or Painful Joints	○ Yes	○ No
6. Shortness of Breath	○ Yes	○ No	15. Ankle Swelling	○ Yes	○ No
7. Chronic Cough	○ Yes	○ No	16. Venereal Disease	○ Yes	○ No
8. Rectal Bleeding	○ Yes	○ No	17. Epilepsy	○ Yes	○ No

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Patient Registration Form

Patient Information	Last Name:	First Name:	M.I.:	Previous Name (If applicable)
	Mailing Address: Apartment:		City/State/Zip:	
	Home Phone:	Cell Phone:		Work Phone w/ext:
	Family Physician:	Date of Birth:		Sex: □ Male □ Female
	Marital Status:	Social Security #:		
	Employer Name:		Employer Address:	
	Emergency Contact:	Phone:	Relationship to Patient:	

Insurance & Paymern Information	Person responsible for the bill (**ONLY IF DIFFERENT THAN THE INSURED**): Name:		
	Date of Birth:	Social Security #:	Phone:
	Address of Person Responsible:		City/State/Zip:
	Employer of Person Responsible:	Relationship to Patient:	
	Primary Medical Insurance	Secondary Medical Insurance	
	Ins. Co. Name	Ins. Co. Name	
	Policy Holder Name:	Policy Holder Name:	
	Insurance ID #:	Insurance ID #:	
	Employer Name:	Employer Name:	

Additional Information					
	Email Address:	Can we leave a message regarding your medical care & test results? □ Yes □ No			
	Race (please select one):	□ American Indian or Alaska Native	□ Aslan	□ Black or African American	
	□ Hispanic	□ Native Hawalian or Pacific Islander	□ White	□ Other	□ Decline
	Ethnicity (please select one):	□ Not Hispanic or Latino	□ Hispanic or Latino	□ Decline	□ Other
	Language	□ English □ Spanish	□ Decline	□Other:_____	
	Preferred Pharmacy Name & Location:				

I have read and agree to the New York Hand Surgery payment policy. I understand that payment is my responsibility regardless of Insurance coverage. I hereby authorize NYHS to furnish insured's Insurance company all information (Including HIV, sexually transmitted diseases, drug/alcohal abuse, mental illness, or psychiatric treatment) which may be requested concering my illness or Injury. I also authorize the release of information regarding work related injuries to my employer. I hereby assign to NYHS all money to which I am entitled for medical expenses related to the services performed from time to time by NYHS, but not to exceed my Indebtedness to NYHS. Any money received from such Insurance company over and above such Indebtedness wll be refunded to me when my bill is paid in full. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside billing service. If my account is sent to an outside billing service there will be a setup fee up to $20.00 and finance charge(s) (1% per month/APR 12%). Note: Medicare patients will not be charged the setup fee or finance charge(s).

MEDICARE BENEFICIARIES: As a Medicare patient, I understand that interest will not be Imposed on any outstanding balance. I request that payment of authorized Medicare benefits be made to NYHS. I authorize any holder of medical information about me to release to NYHS and its agents any information needed to determine these benefits payable for related services.

Signature of Responsible Party: X_____Date:_____

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Vipul P Patel, MD
Board Certified Orthopedic Surgeon
Hand and Upper Extremity Surgeon

330 9th street, Brooklyn, New York 11215
(718) 369-HAND(4263)
(718) 369-4265
info@nyhanddoctor.com
www.nyhanddoctor.com

RECEIPT OF HIPAA PRIVACY NOTICE

Date: _____

I, _____ hereby authorize New York Hand Surgery, PC to discuss my Medical Information with the following Individuals:

NAME	RELATIONSHIP

ACKNOWLEDGEMNT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received copy of New York Hand Surgery Queens, PC's Notice of Privacy Practices.

_____ _____

Signature Date

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Date : _____

Patient Financial Responsibilities

Co- Payment & Deductible

You are responsible for your deductible & co-payment. Your co-payment is due at the time of service. If your deductible has not been satisfied, payment may also be required at the time of service. Your signature below confirms you have been advised.

Non-Covered Services including DME (Durable Medical Equipment)

If Services provided are not covered by your health insurance carrier, you may be responsible for payment on those services. Your Signature below confirms you have been advised and also constitutes an agreement to pay for such services.

Out of Network Services

New York Hand Surgery Queens, PC does not participate with **United Healthcare, The Empire Plan, Aetna, Cigna, Emblem, GHI and Oxford Insurance**. If you are covered by any of these plans, we do not have a contract with your health carriers. As a result, you may be financially responsible for a higher share of the fees, than a provider within your network. **YOU MAY ALSO RECEIVE THE CHECK DIRECTLY FORM YOUR CARRIER**, your signature below confirms you have been advised and constitutes an agreement to pay your portion of the out of network fees and release the issued check to New York Hand Surgery Queens, PC.

Member Appeal Authorization

I hereby authorize New York Hand Surgery Queens, PC and its agents to represent me, and act on my behalf regarding my medical health claim determination, in the event my claim is denied and/or if my claim is processed below my level of benefits.
I authorize my insurance carrier to release my protected health information to my representative for the purpose the appeal. I understand this information in privileged and confidential and will only be released as specified in this authorization or permitted by law.
This authorization will expire upon resolution of this appeal.

_____	_____	_____
Patient Signature or Legal Guardian	**Print Name**	**Date**
_____	_____	_____
Employee Signature	**Print Name**	**Date**

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PRIVATE ASSIGNMENT

Date: _____

I,_____ as a patient of Dr. _____, understand that I am responsible for the fee for services rendered to me by the facility. I understand that I am responsible for:

- My yearly deductible, as dictated by my Insurance company.
- I agree to forward any Insurance checks that I may receive for services rendered by Dr. _____ as soon as they are received by me and that by not doing this, I am committing insurance fraud, which will severely affect my credit.
- To contact my Insurance company to make sure my office is it ls covered if it Is not, I will be held responsible for the services rendered.
- I understand that I'm responsible for any referral or authorization If required by my insurance company.
- I am responsible for any balances if my Insurance company denies payment.

I have read and understand all of the above terms and conditions on this agreement.

_____ _____

Name of Responsible Party (Please print) **Signature of Responsible Party**

ACCOUNTS OVER 30 DAYS WILL CHARGED A $15 MONTHLY FINANCE CHARGE