Paramus Hand Surgery
140 Route 17 North Suite 323
Paramus, NJ 07652
201.483.9555

PARAMUS HAND SURGERY

Demographic Information – WC/MVA

Welcome to Paramus Hand Surgery, we are happy to assist you!
Please fill in the information below**:**

_____ _____ _____
First Name Middle Name Last Name

_____ _____ _____ _____ _____
Date of Birth Age Gender Social Security Marital Status

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Cell Phone Home Phone E-Mail

_____
Emergency Contact and Phone Number

Reason for Visit

Description of Problem: _____

Duration of problem? _____

Rate your pain 0-10 (10 being the worst): ___ / 10

How did you hear about our office:_____

Which hand do you write with? Right / Left
Which hand has a problem? Right / Left / Both

Occupation(s): _____
Sports: Golf / Tennis / Football / Baseball / Basketball / Running / Yoga / Gym / Bowling

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Worker's Compensation and Motor Vehicle Insurance Information

Insurance Co. Covering Injuries: _____

Insurance Co. Address: _____

Claim #: _____ Adjustor: _____ Telephone #:_____

Lawyer Name & Number: _____

Worker's Compensation

Employer: _____ E-Mail: _____

Employer Address: _____ Employer Phone:_____

Motor Vehicle

How/where did accident occur? _____

Date of Injury or Accident: _____

Description of Problem(s): _____

Previous Treatment: _____

Secondary Insurance Information

Insurance Name: _____ ID:_____

Policy Holder: _____ Relationship to Patient:_____ Birthdate:_____

I hereby authorize payment from the insurance company to be sent directly to the office of Steven Ugras, M.D for any service rendered to me by the group. I also authorize the release of medical information to my insurance company in order for the office of Steven Ugras, M.D to complete necessary forms. I am personally responsible for payment of bills, if my claim is denied (for any reason). I am responsible for any co-insurance amounts, non-covered charges, and any balance remaining after insurance payment to your office. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees will be given to me concerning the results of any treatment or operation. Dr. Steve Ugras will attempt to improve me over my present status but cannot guarantee to return me back to normal status.

Patient Signature: _____ Date:_____

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PATIENT QUESTIONNAIRE

Do you have any allergies? (Please circle) Yes or No
If yes, please list along with the reaction that occurs**:** _____

_____

Are you taking any medications? (Please circle) Yes or No
If yes, please list along with the dosage**:** _____

_____

Are you currently experiencing any of the following? (Please circle) Yes or No

Constitutional – Fever, Night sweats, Weight loss/gain, Rash/Hives, Swollen glands	**Throat** – Sore throat, Excessive thirst
Musculoskeletal – Leg swelling, Tremor, Easy bruising	**Eyes**- Red/itchy eyes, Blurring vision
Neurologic - Headaches	**GI** – Urinary issues, Diarrhea
Nasal – Nose bleeds, sinus congestion	**Pulmonary** – Wheezing, Shortness of breath
Ears- Hearing loss,	**Cardiac** – Chest pain

Past Medical History: (Please circle) Yes or No

Rheumatoid Arthritis	High Blood Pressure	High Cholesterol	Cancer	Cataracts	COPD
Heart Disease/Attack	Lyme Disease	Thyroid Disease	Diabetes	Aneurysm	Gout
Congestive Heart Failure	Bleeding Disorder	Kidney Disease	Depression	Anxiety	Seizures
Multiple Sclerosis	Enlarged Prostate	Gastric Reflux	Hepatitis	Anemia	Asthma
Stomach Ulcer	Vascular Disease	HIV Positive	Liver Disease	Sleep Apnea	Emphysema

Other:
_____

Family History: (Please circle) Yes or No

Diabetes	High Blood Pressure	Dupuytren's Contracture	Kidney Disease	Thyroid Disease
Cancer	Malignant Hypothermia	Bleeding Disorder	Rheumatoid Arthritis	Coronary Artery Disease

Other:
_____

Past Surgical History (Please circle) Yes or No

Surgery	Date	Surgery	Date	Surgery	Date
Knee Arthroscopy (Right / Left)		Peripheral Bypass		Eye Surgery	
Joint Replacement (Knee / Hip)		Gallbladder Removal		Hernia Repair	
Spine Surgery (Neck / Back)		Coronary Artery Bypass		Stents	
Shoulder Arthroscopy (Right / Left)		Cardiac Catheterization		Hysterectomy	

Other:
_____

Social History:

- Do you smoke? **Please circle: Yes or No**
  - Have you quit? Yes or No How much do you smoke? _____
- Do you drink alcohol? **Please circle: Yes or No**
  - Please circle: Social only / Several times a week / Everyday
- Do you or have you used illicit drugs? **Please circle: Yes or No** If yes, what kind? Marijuana / Cocaine / Heroin

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Office Policies

These are our established office policies:

1. If your health insurance requires you to obtain a referral, it is your responsibility to bring the referral with you to your visit, or ensure that our office has received it. If you are told that the referral will be sent to our office, you must call us and verify that it has been received. If you have a referral, please verify that it can still be used. Referrals expire after a period of time and after a specific number of visits. You are responsible for fees if the referral is not in.
2. Your co-pay is due at the time of service. We accept cash, and most credit cards. No $100 bills or checks, please.
3. Self-pay patients must pay up front for their visit. There may be additional fees for procedures or x-rays.
4. You are responsible for making sure that our office is notified of **ANY changes in insurance, address, or phone number**. We cannot properly bill your insurance company without this information. In the event you have given us outdated information, the balance becomes your responsibility.
5. Missing a visit without 24 hour notice will result in a fee of 50 dollars and may also result in being discharged from our practice.
6. Surgeries must be cancelled or rescheduled with 48 hour notice, or you may be discharged from the practice and assessed a fee of 150 dollars. Cancelling surgery twice, even with appropriate notice may result in discharge from the practice.
7. Any testing ordered by your physician will be reviewed during a follow-up office visit.
8. Patients are responsible, to pay promptly, and in full any amounts due to the provider, including co-payments, deductibles, returned check fees, and amounts due for non-covered services (such as appeals) that are not payable by my insurance, worker's compensation, lawyer, etc. Patients that do not pay their balances will incur additional fees to cover the costs of collections agencies, lawyers, etc.
9. Any payments written by check that are returned from the bank will be charged a $35 fee additional to the funds previously owed.
10. If you are non-compliant with your treatment as recommended by your physician, you may be discharged from our practice at any time

I have read, understand, and accept the policies.

Patient Signature: _____ Date: _____

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HIPAA Privacy Authorization Form

Authorization for use or disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization
I authorize _____ (healthcare provider) to use and disclose the protected health information described below to (individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of health care from:
a. Date Range: _____
OR
b. All past, present, and future periods.

3. Extent of Authorization
a. I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HlV or AIDS, and treatment of alcohol or drug abuse).
OR
b. I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read, understand, and accept this policy.

Patient Signature: _____ Date:_____

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MVA/WC ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Address: _____

Date of Loss: _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to _____, hereafter referred to as "the medical provider" to pursue and obtain payment on my behalf. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

2. I, assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. If it is determined that more than one insurance company is responsible for payment of my medical bills I hereby authorize and give the medical provider power of attorney to sign any documents on my behalf to pursue a claim for personal injury protections benefits. However, upon consent of both parties, same shall be revocable.

3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement made on my behalf.

5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.

6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

Signed: _____

Patient's Name: _____

Dated: _____