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

PARAMUS HAND SURGERY

Demographic Information

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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Insurance Policies

PRIMARY INSURANCE INFORMATION

Insurance Name:_____ ID:_____

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

SECONDARY INSURANCE INFORMATION

Insurance Name:_____ ID:_____

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

TERTIARY INSURANCE INFORMATION

Insurance Name:_____ ID:_____

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

If the office of Steven Ugras, M.D. participates in your health insurance, we will bill your carrier for any eligible charges that you incur. We will assist you in obtaining authorization for HMO & Managed Care treatment, but **YOU** are responsible for making sure that the appropriate referrals are acquired and are **up to date** with appropriate number of treatment approved. **You are responsible** for payment of any co-insurance amounts, non-covered charges, and denied claims.

If the office of Steven Ugras, M.D participates does not participate in your health insurance, you are responsible for payment of charges at the time of service. You are responsible for any balance remaining after insurance payment to our office. If my insurance company has not paid a claim you submitted for me within 60 days, payments are my responsibility.
It is your responsibility to notify your insurance company & **obtain pre-authorization**, if any surgery or hospital admission is planned. We will be happy to assist you in determining your likely balance due after expected insurance payment & can help arrange a method of payment. Your health insurance is a contract between you & your insurance company. We cannot accept responsibility for negotiating any type of settlement on a disputed claim if your pre-authorization is not obtained.

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 the necessary insurance forms. I give permission to **the office of Steven Ugras, M.D** to appeal any denials or under payment received from my insurance company.

I am aware that the practice of medicine & surgery is not an exact science and acknowledge that no guarantees will be given to me concerning the results of any treatment or operation. Dr. Steven Ugras will attempt to improve me, but cannot guarantee to return me 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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ASSIGNMENT OF BENEFITS, AUTHORIZATION TO SETTLE CLAIM AND DIRECTION TO PAY MEDICAL PROVIDER DIRECTLY

By my signature below, for good and valuable consideration (including but not limited to the extension of credit to me), I hereby assign, transfer and convey to **Paramus Hand Surgery** (hereinafter "the Provider") all of my rights, title and interest in and to medical expense reimbursement in whatever form, including but not limited to any automobile liability medical expense payments or other health benefits indemnification and/or agreement otherwise payable to me. This payment shall not exceed my indebtedness to the above named assignee and I acknowledge that I will timely pay any indebtedness owed by me to the assignee that is not otherwise satisfied by the above-mentioned assigned proceeds. I also acknowledge that any medical expenses not covered under my insurance policy will be my responsibility.

I further authorize the Provider to negotiate, collect and settle any claim with any insurance carrier or other third party payor with regard to these services, which authorization shall include authority to:
(1) request and receive from any insurer or any other party any and all documentation and records that I am empowered to request regarding this claim, including, without limitation, a statement of coverage, policy declarations page and insurance policy pursuant to Section 627.4137. In addition, the provider has the authority to request and receive any Independent Medical Examination Reports, notices sent to me regarding appointments for Independent Medical Examinations and Examinations Under Oath (including proof of mail), Records Review Reports, coverage denial letters, Explanations of Benefits, and Benefit Payment Sheets or Logs (P.I.P. Payout Sheets), without regard as to whether such documentation has already been provided to me and,
(2) to endorse in my name any check issued for payment where benefits were assigned. By way of this assignment and notice, I further instruct you, the insurer, to furnish to Provider copies of all future notices affecting Provider's interest in this claim, including, without limitation, any notices of requested medical examinations or statements.

The Provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit *shall not* be deemed a waiver, *accord, satisfaction*, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full.

I further direct my insurer to direct all payments for services rendered by the Provider directly to Provider at the billing address contained on Provider's medical bills.

THIS IS A DIRECT AND IRREVOCABLE ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY OF INSURANCE.

A photocopy of this form shall be considered as effective and valid as the original.
I have read the foregoing and understand and agree to each of the above provisions:

_____	_____	_____
Patients Name	Patient Signature	Date