Print Form

AUSTIN HAND GROUP

Ira G. Lown, M.D., F.A.C.S. **www.austinhandgroup.com**

3345 Bee Cave Road
Suite 101
Austin, TX 78746

Phone (512) 327-HAND (4263)
Fax (512) 327-4265

Today's Date

Patient Information

Patient Name SSN/ID#

Sex ☐M ☐F Age Birthdate

Marital Status: ◯Minor ◯Widowed ◯Single
◯Separated ◯Divorced ◯Married

Address

City State Zip

E-Mail

Home Phone Cell Phone

Patient Employer/School

Employer/School Address

Employer/School Phone

Primary Insurance Carrier Phone

Address

Policy Holder Insurance I.D. #

Policy Holder Birthdate Insurance Group #

Policy Holder's Address (street, city ,zip)

Home Phone Cell Phone

Policy Holder's Employer

Relationship to Patient Co-Pay Amount

Secondary Insurance Carrier Phone

Address

Responsible Party (if other than yourself)

Policy/ID number Co-Pay Amount

How did you hear about Austin Hand Group?

◯The Outlook ◯Yellow Pages ◯A Patient ◯Internet Search
◉Physician Reference ◯Google ◯A Friend ◯Insurance website
◯austinhandgroup.com

If patient, physician or friend, please tell us whom so we may thank them.

IN CASE OF EMERGENCY

Name Relationship

Phone

*Consent to treat if patient is a minor: _____ Date: _____

Patient Medical History

Are you? ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Height _____ Weight _____

Chief Complaint: _____

Which side is your problem on? ☐ Right ☐ Left ☐ Both

Date of injury/ accident: _____ When did symptoms begin? _____

Briefly Describe Your Injury: _____

_____

Was this an injury? ☐ Yes ☐ No

Were you at work? ☐ Yes ☐ No

Motor vehicle related injury? ☐ Yes ☐ No

If so, do you have an Attorney? ☐ Yes ☐ No

Name of Attorney _____

Pain and Symptoms of Current Chief Complaint

☐ Numbness/ Tingling	☐ Swelling	Is the pain?
Describe: _____	☐ Decreased motion	☐ Constant
☐ Pain scale (0-10)	☐ Catching/ Locking	☐ Off/ On
Describe: _____	☐ Activity pain	☐ Improving
☐ Trouble Sleeping	☐ Pain after activity	☐ Same
☐ Drop things	☐ Weakness	☐ Worse

Treatment You have had for current injury

☐ Pain Medication	☐ Hand Therapy	☐ Rest
☐ Anti-inflammatory Meds	☐ Cortisone injection	☐ X-Rays
☐ Antibiotics	☐ Oral steroids	☐ No treatment
☐ Splinting	☐ CT	
☐ Casting	☐ MRI	

Past Medical History

☐ Asthma	☐ Emphysema	☐ Lupus
☐ Arthritis	☐ Fainting Spells	☐ Lung Problems
☐ Alcoholism	☐ Gout	☐ Migraine
☐ Anxiety	☐ High Blood Pressure	☐ Kidney Problems
☐ Bleeding Disorder	☐ Hepatitis A, B or C	☐ Thyroid Problems
☐ Cancer	☐ Heart Attack (date _____)	☐ Tuberculosis
☐ Diabetes	☐ Heart Trouble	☐ Stroke
☐ Depression	Describe _____	☐ Seizure Disorder
☐ Digestive Problems	Cardiologist _____	☐ Skin Disorder

Who is your Primary Care Physician? _____

Past Surgical History (please list all surgical procedures you have had)

Current Medications (please list all medications you are taking)

Drug Allergies (please list all medication allergies)

Other Allergies or sensitivities

Latex: ☐Yes ☐No Tape: ☐Yes ☐No

Social History

Do you use Tobacco Products? ☐No ☐Half pack /day ☐pack/day

Do you consume alcoholic beverages? ☐No ☐Daily ☐ Socially

Occupation:

Are you currently working? ☐Yes ☐No

Family Medical History

☐Arthritis ☐Cancer ☐Heart Disease

☐Diabetes ☐High Blood Pressure ☐Lung Disease

Review of Systems (please mark all that apply)

☐ Fever/Chills	☐ Trouble Breathing	☐ Incontinence
☐ Weight loss/ gain	☐ Persistant Cough	☐ Muscle pain
☐ Blurred vision	☐ Loss of appetite	☐ Stiffness
☐ Hearing loss	☐ Nausea/ Vomiting	☐ Arthritis
☐ Nose bleed	☐ Diarrhea	☐ Easy bleeding
☐ Hoarseness	☐ Constipation	☐ Loss of sensation
☐ Chest Pain	☐ Indigeston	☐ Anxiety
☐ Shortness of breath	☐ Skin rash	☐ Depression
☐ Trouble sleeping	☐ Itching	☐ Headache

Patient Signature: _____ Date: _____

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Office Policies and Procedures

We would like to take this opportunity to personally thank you for choosing Austin Hand Group to treat your needs and concerns. Below is a list of our office policies. Please take a moment of your time to review our policies and please do not hesitate to ask any questions. *After reviewing the policies below, please sign the bottom indicating you have read, understand, and will adhere to the written policies.*

- **Patient treatment:** It is our primary goal to restore and maintain the function of your hands. We strive to provide you with the best health care possible. If you have any questions regarding your treatment, please feel free to consult with your physician.
- **Appointments:** If you are unable to keep your appointment we require that you contact our office. Also as a courtesy, we require that patients arrive on time to their scheduled appointment.
- **Release of Records:** If you want your records released to another physician or facility you must sign a Release of Information form indicating who we are releasing records to, as well as, which relevant information you would like us to release. If you wish to receive a copy of your records for personal use, you must send a written request. Please allow 7-10 business days to have your records available. We do not release films for x-rays; however, copies of the films are available for $8.00 per film.
- **Referrals:** If your insurance requires a referral, it is your responsibility for obtaining it. The contract is between you and your insurance carrier. Therefore, we are not responsible to obtain your referral. If you present to the office without a referral you will be required to reschedule your appointment or you may opt to payout of pocket for services rendered.
- **Insurance:** Your insurance coverage is a contract between you and your insurance company. We are not a party to this contract. Your insurance company does not guarantee payment for services rendered. Your insurance company makes the final determination of benefits and eligibility at the time the claim is reviewed. **By signing the line below you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance carrier.**
- **Verification of Benefits:** You as the policyholder are primarily responsible to know your insurance benefits. **The insurance DOES NOT guarantee payment of benefits and you will be responsible for any coinsurance or deductibles for services not covered by your insurance carrier.** If your insurance information should ever change you must let us know, otherwise you will incur all charges.
- **Required Payments: You will be responsible to pay any co-payment, deductible, coinsurance, or fees not covered by your insurance carrier at the time services are rendered.** We do not accept letters of protection. You may choose to pay by cash, check, or credit card.
- **Monthly Statements:** You will receive a statement if you have an outstanding balance on your account. The statement will reflect any balance pending with your insurance carrier as well as any outstanding balance for services not covered by your insurance company. We request that if you receive a statement, that you make payment within 10 days of receipt.

Signature_____ Date_____

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NOTICE OF PRIVACY PRACTICES

This page serves to inform you of the privacy practices of Austin Hand Group and it's representatives. The privacy of your medical information is important to us. We intend to honor your privacy in every way possible. By signing below you will allow us to disclose your personal health information: I, _____understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and evaluation information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have reviewed and understand the Notice of Information Practices. I understand that I have he right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

We respect your rights in maintaining the utmost in privacy in regards to your individual health information. We will not release any of your health information to non-medical entities without your prior written permission. Austin Hand Group maintains physical and electronic safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets and controlled computer network systems and password accounts.

We will only disclose your medical information to your health plan or other health care professionals or facilities for purposes of diagnosis or treatment of your medical condition. If you prefer that we do not disclose any or all of your medical condition(s), please inform us so that we may take any necessary precautions.

☐ No restrictions

☐ I request the following restrictions to the use or disclosure of my health information:

_____

Signature:_____ Date: _____