SIGHT OF HAND
PATIENT REGISTRATION FORM

PATIENT NAME_____ **DATE**_____

STREET ADDRESS_____

CITY_____ **STATE**_____ **ZIPCODE**_____ **EMAIL** _____

TELEPHONE NO. (H)_____ **(W)**_____ **(C)**_____ **(F)**_____

SEX_____ **DATE OF BIRTH**_____ **SSN**_____

PRIMARY CARE PHYSICIAN_____ **REFERRED BY**_____

EMERGENCY CONTACT NAME AND PHONE NO._____

INSURANCE INFORMATION

Is this a personal injury or automobile accident claim? Yes no I don't know
If yes, do you have an attorney? Yes no **Please complete the auto/liability claim form, which is available from the receptionist.**

1) **PRIMARY HEALTH INSURANCE PLAN NAME**_____

INSURANCE ID#_____ **GROUP ID#**_____

SUBSCRIBER'S NAME (if different than patient) _____

SUBSCRIBER'S SSN_____ **DOB**_____

2) **SECONDARY INSURANCE PLAN NAME**_____

INSURANCE ID#_____ **GROUP ID#**_____

SUBSCRIBER'S NAME (if different than patient) _____

SUBSCRIBER'S SSN_____ **DOB**_____

This section only needs to be filled out if patient is under the age of 18

MOTHER'S NAME_____ **FATHER'S NAME**_____

STREET ADDRESS_____ **STREET ADDRESS**_____

City, State, ZIP_____ **City, State, ZIP**_____

SSN_____ **DOB**_____ **SSN**_____ **DOB**_____

SIGHT OF HAND
Initial Visit Patient Questionnaire

Name_____ **Date**_____
DOB_____ **Primary Care Provider**_____

What brings you here for your visit today?_____

Please tell us more about your pain.

Location of Pain	Describe (sharp, dull, shooting, throbbing, aching…)
i.e. Right side of low back	**Intermittent; sharp and shooting**

When did the pain begin?_____
Was the onset of pain: (check one) sudden or gradual?

Trauma history: Please list your age and type of trauma you have experienced from birth to present including falls, motor vehicle accidents and emotional trauma (Example: birth: vacuum extraction; 8 y/o: fell down stairs, lost consciousness, broke left leg)_____
_____
_____
_____
_____
_____
_____
_____

Is the pain the result of a work-related injury? yes no unknown
Is the pain the result of an automobile or personal injury claim? yes no unknown

If you have **headaches**, how many days per month have you had them during the past 3 months?
0-5 6-10 11-15 16-20 21-25 26-30 more than one a day
Do you have any other symptoms before or during a headache?_____
What brings on, or triggers your headaches?_____

Please circle the number on the line below that describes the overall amount of pain you are experiencing today:
No pain----------worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes the worst your pain has been in the last month:
No pain----------worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes the least your pain has been in the last month:
No pain----------worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Is your pain worse (check the box that best applies):

☐ At night	☐ In the morning	☐ End of shift/day	☐ Hot, humid days
☐ No difference day or night	☐ Wet/cloudy days	☐ Cold days	☐ Certain time of year

Please circle the number on the line below that describes your ability to sleep at night:

Didn't sleep a wink----------fell asleep immediately and

0 1 2 3 4 5 6 7 8 9 10 slept all night

Check the box that best describes your emotional health (check ONE):

☐ Happy/cheerful	☐ Optimistic	☐ Anxious	☐ Worried
☐ Angry	☐ Depressed	☐ Suicidal	☐ Compulsive
☐ Indifferent	☐ Hopeless	☐ Frustrated	☐ Panicked
☐ Other (please explain):			

Which of the following activities increase or decrease your pain? (Place an ⇧ or ⇩ in the small boxes)

☐ **Getting out of bed**	☐ **Standing up**	☐ **Prolonged standing**	☐ **Sitting**
☐ **Bending backward**	☐ **Lying on back or side**	☐ **Looking up or sideways**	☐ **Washing/combing hair**
☐ **Lifting**	☐ **Twisting**	☐ **Straining**	☐ **Reaching over**
☐ **Coughing/sneezing**	☐ **Leaning forward**	☐ **Going downstairs**	☐ **Long car rides**
☐ **Exercising**	☐ **Computer work**	☐ **Reading**	☐ **Walking**
☐ **Running**	☐ **Other:**		

What tests/treatments have you had for your current problem(s)? **Where?**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History: Please check any conditions you have or have had in the past:

☐ AIDS/HIV positive	☐ Alcoholism	☐ Anemia	☐ Anorexia
☐ Appendicitis	☐ Arthritis	☐ Asthma	☐ Bleeding disorders
☐ Blood clots	☐ Cancer	☐ Diabetes	☐ Drug dependency
☐ Emphysema	☐ Epilepsy/seizures	☐ Glaucoma	☐ Goiter
☐ Osteoporosis	☐ Gout	☐ Heart disease	☐ High cholesterol
☐ High blood pressure	☐ Kidney disease	☐ Liver disease/hepatitis	☐ Migraines
☐ Prostate problems	☐ Psychiatric care	☐ Acid reflux (GERD)	☐ Stomach ulcers
☐ Stroke	☐ Thyroid problems	☐ Irritable bowel	☐ depression

Comments:_____

_____

Past Surgical History: Please list all surgeries you have had and the approximate year:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medications: Please list all of the medications (with dosages if possible) you are taking. Include over-the-counter medications as well.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: Are you allergic to any medications/substances? ☐ No ☐ Yes: _____
_____
_____
_____

Social History: Do you smoke or chew tobacco? ☐ No ☐ Yes _____packs per day for _____years
Did you ever smoke or chew tobacco? ☐ No ☐ Yes When did you quit?_____
Alcohol intake: ☐ Never ☐ Rare ☐ Occasional; Average number of drinks per day:_____
Do you currently, or have you ever used recreational drugs? ☐ No ☐ Yes
Occupation (current or previous):_____
Are you working: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled
Are you married / single / divorced / widowed? _____happily?
Do you have any children? If yes, what are their ages?_____
_____

Family History: Have your relatives had any of the following medical problems?

Blood Relative	Arthritis	Migraines	Cancer	Joint problems	Osteoporosis
Mother					
Father					
Brother/Sister					
Children					
Grandparents					

Review of Systems: Please check any problems you are now having or have had repeatedly in the last month

☐ Fatigue	☐ Fever	☐ Weight change	☐ Weakness
☐ Headaches	☐ Dizziness	☐ Head injury	☐ Confusion
☐ Vision changes	☐ Hearing loss	☐ Ear aches	☐ Sinus trouble
☐ Trouble swallowing	☐ Jaw pain	☐ Chest pain/pressure	☐ Shortness of breath
☐ Rapid heart beat	☐ Irregular heart beat	☐ Calf pain with walking	☐ Swelling of ankles
☐ Blood clots	☐ Chronic cough	☐ Coughing up blood	☐ Wheezing
☐ Poor appetite	☐ Heartburn/indigestion	☐ Belly pain	☐ Diarrhea
☐ Constipation	☐ Rectal bleeding	☐ Nausea/vomiting	☐ Poor bowel control
☐ Painful urination	☐ Poor bladder control	☐ Difficulty urinating	☐ Rash/hives
☐ Painful/swollen joints	☐ Back pain	☐ Arm or leg pain	☐ Difficulty walking
☐ Convulsion/seizures	☐ Numbness/tingling	☐ Weakness arms/legs	☐ Difficulty sleeping
☐ Depression	☐ Anxiety	☐ Excess thirst/urination	☐ Easy bruising/bleeding
☐ Other (please describe)			

Comments_____
_____

For women: Date of last menstrual period:_____
History of irregular or painful periods? ___No ___Yes

What is your goal for today's visit?_____

You authorize the release of office notes to your primary care physician and referring physician by signing here:_____
Patient Signature

Reviewed by:_____ Date:_____

SIGHT OF HAND FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked and initial it.

____ Patient with Insurance: You are responsible for deductibles, copays, non-covered services, coinsurance, and items considered "not medically necessary" by your insurance company. Co-payment amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

____ Patient without Insurance (Private Pay): Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to visit to meet without billing specialist.

____Personal injury (accident): If you are a personal injury/automobile accident patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for services rendered will be your responsibility. Please give all information needed for billing. If statements are to be sent to your attorney instead of to an insurance company, a lien must be signed by your attorney guaranteeing payment for services rendered.

____Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays and any non-covered services.

____ Patient without proof of Insurance: If you do not have evidence of health insurance, or complete information regarding your worker's compensation claim or personal injury claim at the time of visit, cash payment will be required at the time of visit. If we then receive the appropriate insurance/claim information and obtain payment, your cash payment will be refunded promptly.

____Non-participating provider: We do not participate with _____. If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

SIGHT OF HAND
GUARANTEE OF PAYMENT
Please initial each section on the line provided.

____ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.

____ I have been advised that if my health insurance carrier/HMO/Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in adavance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

____ I authorize payment of benefits from my insurance carriers directly to SIGHT OF HAND. [If I choose not to initial this item, the benefit payments will be paid to me and I will be responsible for paying SIGHT OF HAND].

____ Cancellation Policy:
I understand that there is a $50 fee charged for all appointments missed or cancelled with less than 24 hours notice (business day). This fee must be paid prior to scheduling another appointment.

____Minor Patients only:
The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

PAYMENT IS REQUIRED AT TIME OF SERVICE
THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS

I have read and understand my financial responsibilities as outlined in both pages of this SIGHT OF HAND Financial Policy document.

X_____ _____

Patient's Signature Date

_____
Patient's Printed Name

_____ _____
Printed name of person signing on behalf of patient Relationship to patient

SIGHT OF HAND CONSENT FORM / PRIVACY NOTICE
Please initial each section on the line provided.

____ Consent for Treatment:
I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

____ Medical Release Authorization:
With my consent, SIGHT OF HAND may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

To review the more comprehensive version of this notice or if you have any questions, please contact our office administrator at 971-303-5044

SIGHT OF HAND is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.

Practice Privacy Policy
At SIGHT OF HAND your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

Patient Health Care Information Use & Disclosure
Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

____Consent for Contact:
With my consent, SIGHT OF HAND may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

SIGHT OF HAND

Practice Duties – Regarding your health care information
SIGHT OF HAND is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

SIGHT OF HAND is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

Patient Rights – Regarding their health care information
The patient has the right to request the practice to restrict use and disclosure of protected health information. SIGHT OF HAND is not required to agree to the requested restriction.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to SIGHT OF HAND's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SIGHT OF HAND may decline to provide treatment to me.

X_____ _____
Patient's Signature Date

_____
Patient's Printed Name

_____ _____
Printed name of person signing on behalf of patient Relationship to patient