

Lankford Hand Surgery Association

Patient Information Sheet

PLEASE PRINT:

Patient's Full Name: _____ DOB: _____

Home Address: _____ Age: _____

_____ Home Phone: (____) _____

[] Male [] Female [] Single [] Married Cell Phone: (____) _____

Social Security Number: _____

Driver's License Number: _____ State: _____

Email: _____ (For electronic medical records)

Employer: _____ Work Phone: (____) _____

Occupation: _____

Name of Spouse: _____ Phone Number: (____) _____

PRIMARY INSURED INFO: (please do not fill out if work. comp.)

Relationship to Patient: _____ Full Name: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____ Work Phone: _____

CLOSEST RELATION TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE):

Name: _____ Relationship: _____ Phone: (____) _____

Who referred you to our practice? _____

If another doctor, give phone number and/or address: _____

Have you or a family member seen any of our doctors previously as a patient: [] Yes [] No When? _____

If yes, who? [] Self [] Family Family member: _____

If yes, which doctor? _____ Where? [] Office [] Hospital

CONTINUED ON BACK →

Lankford Hand Surgery Association

INSURANCE INFORMATION:

Please present your identification card so that we may make a copy for our records. Also, **please list the appropriate identification numbers below.**

Name of Insurance Company: _____

Certificate/Identification Number: _____ Group: _____

Name of Policy Holder: _____ Effective Date: _____

Medicare Number: _____ Effective Date: _____

Medicaid Number: _____ Effective Date: _____

All professional services rendered are charged to the patient except in cases of **prior** approval. Insurance claims are filed by this office unless required under specific contracts and all authorizations are complete.

Worker's Compensation: Complete information must be provided and approved **prior** to your visits for charges to be covered.

HMO/PPO: If the patient has a referring doctor, the **patient's** is responsible for having the doctor call us with an authorization number **prior** to being seen.

Medicare/ Medicaid: The patient must present a **current valid** identification card. We are **not** in network with any Medicare replacement plans.

WE DO NOT FILE SECONDARY INSURANCE.

Supplies and other items that are not covered by your insurance company will be the responsibility of the patient.

It is the responsibility of the patient to advise this office of any insurance changes **prior** to receiving services. I understand that failure to do so may result in additional financial responsibility on my part.

Date Signed: _____ **Patient's (or responsible party's) signature:** _____

I Hereby authorize any doctor of the Lankford Hand Surgery Association to furnish information to insurance carriers concerning my illness, accidents and treatment; and hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date Signed: _____ **Patient's (or responsible party's) signature:** _____

Please check any of the following medication to which you are allergic:

- Penicillin Iodine Aspirin Antibiotics
- Sulfa Novacaine Codeine Xylocaine
- Tape Other: _____

List of medication you are currently taking:

Check any of the following surgeries you have had and give the date:

- Tonsillectomy _____ Lungs _____
- Gastrointestinal _____ Kidney/Bladder _____
- Appendectomy _____ Hernia Repair _____
- Hysterectomy _____ Hemorrhoids _____
- Heart _____ Hand or Forearm _____
- Other: _____

Review of systems:

Check the medical conditions you are known to have now or in the past:

- High Blood Pressure Convulsions Ulcers Arthritis
- Kidney/Bladder Disease Heart Trouble Asthma Diabetes
- Lung Trouble Tuberculosis Gout Bleeding Problems
- Blackouts Hepatitis Cancer Other: _____

If female, are you pregnant? _____ if yes, give expected delivery date: _____

List any major illness: _____

Family Medical History:

Check if you have any family medical history of the following:

- Tuberculosis Diabetes Arthritis Hemophilia Cancer
- Other: _____

Personal and Social History:

List your occupation: _____

Do you smoke? No Yes Number of packs per day: _____

Do you drink? No Yes Light Moderate Heavy

Patient's Signature: _____ Date: _____

Lankford Hand Surgery Association

3600 Gaston Ave, Wadley Tower #450

Dallas, TX 75246

Phone: (214) 823-5351 Fax: (214) 823-2825

Communication of Health Information

Patient Name

Date of Birth

I hereby give permission to Lankford Hand Surgery Association to disclose and discuss any information related to my **medical** condition(s) and/or **financial** obligations with Lankford Hand Surgery Association with the following relative/close personal friend OR alternate, if listed:

1. _____
Name Relationship Telephone Number

____ Medical Information ____ Financial Information

2. _____
Name Relationship Telephone Number

____ Medical Information ____ Financial Information

____ I do **NOT** wish to give permission for any person (other than covered in the Notice of Privacy Practices according to HIPAA) access to information.

How to contact me:

I wish to be contacted in the following manner:

____ Home Phone: (____) _____

____ Cell Phone: (____) _____

____ Office Phone: (____) _____

Please note that Lankford Hand Surgery Association representatives will **not** leave detailed messages on answering devices or voicemail.

The **duration** of this authorization is **indefinite** unless otherwise revoked in writing. I understand that request for medical information from persons (other than covered in the Notice of Privacy Practices/HIPAA) not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of patient or Legal Guardian

Date

Printed Name

Lankford Hand Surgery Association

Acknowledgement of Review of Notice of Privacy Practices /Office Policies

- All copays, deductibles, coinsurance and patient balances are collected at the time of service.
- We do not file with secondary or 3rd party insurances.
- Disability, Aflac, etc. forms are \$10 per form. Payment is due before forms are completed and please allow 7-10 business days for returned forms.
- Requests for medical records and copies of x-rays require written authorization. Please allow 7-14 business days to complete. Fees may apply.
- Do not call the office to request prescription refills. Call your pharmacy and have them fax a request. Please allow 48 hours.
- Please allow a minimum of 24 hours to cancel and/or reschedule appointments and a minimum of 72 hours to cancel and/or reschedule surgery.
- Cell phones are not allowed in the exam rooms or therapy. They interfere with other electronic devices used throughout our office. Please turn off all cell phones when anywhere other than the waiting room.

I have reviewed this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I have also reviewed and understand the Office Policies. I understand that I am entitled to receive a copy of this document.

Patient Name: _____ Date: _____

Signature: _____

Medicare Policy

Although we treat Medicare patients in this office, we are “non-participating” and do not accept assignment.

We are not allowed by law to treat patients of Medicare age outside of the Medicare Rates.

As “non-participating” physicians we are allowed, however, to charge the higher of the two fee schedules offered by Medicare. This is 15% more than their lower fee but it is still only 55% of our usual fees.

Since we are “non-participating”, Medicare will not reimburse us directly and insists on sending the payment directly to the patient.

We do NOT file secondary insurance, but if your secondary is registered with Medicare then they will automatically send the claim on to your secondary insurance.

Because we have no way to follow up on these Medicare payments and in order to avoid the additional expense of hiring extra staff to do this, we must ask that payment be made at time of service to include, but not limited to, any office procedures, occupational therapy, and any inpatient or outpatient surgery.

Thank you,
The Lankford Hand Surgery Association

Patient Name: _____

Signature: _____ Date: _____