BADIA
Hand to Shoulder Center

Patient Initials: _____

Date of birth: _____

Name of the physician/friend/company that referred you here _____

First Name: _____ **M.I.:** _____ **Last Name:** _____

Nickname: _____ **Sex:** [ ] male [ ] female **Social Security:** _____

Address: _____

Street City State Zip Code

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-mail Address: _____

Marital Status: [ ] single [ ] married [ ] divorced [ ] widowed

Employment Status: [ ] employed [ ] unemployed [ ] retired [ ] disabled

Employer: _____ Occupation: _____

Employer Address: _____

Workers Comp or Auto Insurance Company Name: _____

Address for claims: _____

Street City State Zip Code

Adjuster Name: _____ Phone: _____

Primary Insurance Company Name: _____ Phone: _____

Policy number: _____ Group number: _____

Policy holder name: _____ Date of birth: _____

Social security number: _____ Relationship to patient: _____

Secondary Insurance Company Name: _____ Phone: _____

Policy number: _____ Group number: _____

Policy holder name: _____ Date of birth: _____

Social security number: _____ Relationship to patient: _____

Primary Care Physician: _____ **Phone:** _____

Pharmacy: _____ **Phone:** _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Address: _____

Do you have an Advance Directive? (living will, health care surrogate) [ ] yes [ ] no

I do hearby consent to any medical care which is deemed advisable or necessary by my healthcare provider and grant authority to Badia Hand to Shoulder Center, to administer and perform all examinations, treatments, diagnostic procedures and surgeries needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance, and any other health plan, are assigned to Badia Hand to Shoulder Center. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as the original.

Patient Signature: _____ Date: _____

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Patient Initials: _____

Name: _____ Age: _____ Height: _____ Weight: _____

Dominant hand: [ ] right [ ] left Which side is affected today: [ ] right [ ] left
Reason for visit (include body part affected, brief description of how injury happened): _____
_____
_____

Have you seen a physician in the last 12 months for this issue? [ ] yes [ ] no
If yes, name of treating physician: _____

What medications do you currently take? (include supplements) _____
_____
_____

What allergies do you have? (include medications, foods, and others) _____
_____
_____

Which surgeries have you had? (include type and date) _____
_____
_____

What medical conditions have you been diagnosed with:

	YES	NO	If yes, describe:
Arthritis	____	____	_____
High blood pressure	____	____	_____
High cholesterol	____	____	_____
Diabetes	____	____	_____
Heart or circulation condition	____	____	_____
Liver condition	____	____	_____
Lung condition (asthma, etc.)	____	____	_____
Thyroid condition	____	____	_____
Tuberculosis	____	____	_____
HIV/AIDS	____	____	_____
Any other medical condition	____	____	_____

Social history:

Are you pregnant	[ ] yes	[ ] no	[ ] not applicable
Do you smoke	[ ] yes	[ ] no	Packs per day: _____
Do you use recreational drugs	[ ] yes	[ ] no	Type and frequency: _____

Patient Signature: _____ Date: _____

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Review of Systems

From the date you started experiencing the symptoms for which you are seeing us today, have you had the following:

Constitutional:
- ☐ Fever
- ☐ Chills
- ☐ Trouble sleeping
- ☐ Unintended weight loss or gain
- ☐ Other

Eyes/Ears/Nose/Throat:
- ☐ Blurred vision
- ☐ Sore throat
- ☐ Decreased hearing
- ☐ Nasal discharge
- ☐ Other

Neurologic:
- ☐ Numbness/tingling
- ☐ Dizzy spells
- ☐ Tremors
- ☐ Other

Cardiovascular:
- ☐ Chest pain
- ☐ Varicose veins
- ☐ Other

Respiratory:
- ☐ Frequent cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other

Skin:
- ☐ Rash
- ☐ Itching
- ☐ Color changes
- ☐ Other

Hematologic/Lymphatic:
- ☐ Swollen glands
- ☐ Blood clotting problems
- ☐ Easy bruising
- ☐ Other

Endocrine:
- ☐ Excessive thirst
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Sluggishness
- ☐ Other

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Indigestion/heart burn
- ☐ Other

Genitourinary:
- ☐ Urinary frequency
- ☐ Urine retention
- ☐ Pain/burning with urination
- ☐ Other

Psychologic:
- ☐ Depression
  - ☐ Have you considered suicide
- ☐ Memory loss
- ☐ Other

☐ **None of the above**

Is this an accident related injury? [ ] yes [ ] no If yes, was it: [ ] automobile [ ] work related [ ] other
Is there a third party responsible for your injury? [ ] yes [ ] no
If so, who is responsible? _____
Do you have an attorney on this case? [ ] yes [ ] no
If so, what is the attorney's name and address? _____

I certify that the above information is correct.

Patient Signature: _____ Date: _____

Patient Initials: _____

Financial Policy

This is an agreement between Badia Hand to Shoulder Center, as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money order, cashier's check, Visa and Master Card. We collect copay, coinsurance and any deductible at the time services are rendered.

Insurance: Insurance is a contract between you and your insurance company. We will file insurance claims **only** for plans with whom we have a contract with. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front & back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All copay, coinsurance and deductibles are due at the time services are rendered.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file with your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

Collection fee: A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee currently of **$25.00** for any checks returned by the bank. Payment made on a returned check must be made in cash or by a money order.

Copying of records: You will need to request in writing, and pay a reasonable copying fee ($1/page for the first 25 pages and 25 cents for every page thereafter) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. Copies of images (x-ray, MRI) are available in CD and are subject to a $10.00 fee per disc.

Consent to photograph: I authorize Badia Hand to Shoulder, LLC and its affiliates to take pictures of my (or my child's) medical or surgical procedure(s) and condition(s) and to the use of such pictures for treatment, scientific, educational or research purposes.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents on this form.

Patient name: _____

Responsible party (if not the patient): _____

Patient Signature: _____ Date: _____

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Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of Badia Hand to Shoulder Center Notice of Privacy Practices as required by federal law.

Patient Signature: _____ Date: _____

Reason patient/personal representative failed to sign:

_____

_____

Staff signature: _____

Patient Consent for use and disclosure of Protected Health Information

I, _____, authorize the office Badia Hand to Shoulder Center to disclose protected health information to the following:

Name and relationship of person(s) authorized to receive information:

_____

_____

_____

Telephone Messages

Please circle one:

I **do / do not** authorize the office of Badia Hand to Shoulder Center to leave telephone messages regarding my protected health information on the voicemail or answering machine.

Appointment Cancellation Policy

If you need to cancel your appointment, please notify our office within at least 24 business hours. Failure to do this keeps us from scheduling other patients that need to be seen. A fee will be charged for appointments not cancelled **with 24 hours advanced notice**. This includes cancelled appointments, rescheduled appointments, and missed appointments (no-shows). The fee for this is **$50.00**. This fee will have to be paid at the time of your rescheduled appointment; if no appointment is rescheduled, you will be billed for this fee. The doctor will not see you until this fee has been paid.

By signing below, I certify that I have read, understand, and agree to all four Notices above.

Patient Signature: _____ Date: _____

Patient Initials: _____

Mutual Agreement

Dr. Alejandro Badia, M.C., and Badia Hand to Shoulder Center (collectively labeled "physician") agree to provide treatment to: _____ ("patient"). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patient's best interest. Accordingly, Physician agrees not to provide medical information for the purposes of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician – his practice, expertise, and/or treatment – on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the tie of creation (prior to publication) of the commentary.

This agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _____, 2012

Patient Signature: _____ Date: _____

Patient Initials: _____

Agreement as to Resolution of Concerns

"I", "Patient/Guardian" shall be understood to mean _____. "Physician" shall be understood to mean Alejandro Badia, M.D. / Badia Hand to Shoulder Center.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agrees not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice cause or cause of action be initiated or pursued, I and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these witnesses will be members in good standing of, and adhere to the guidelines and/or code of conduct, defined for expert witnesses by the ASSH and AAOS.

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Physician Signature: _____ Date: _____

Patient Signature: _____ Date: _____