



Thank you for choosing us for your healthcare needs. Enclosed you will find the **New Patient Paperwork**, which must be **completed and brought with you to your appointment**.

Appointment Preparation

- **Identification & Insurance:** Please bring a valid photo ID (e.g., driver's license or state ID) and your medical insurance card. Both are required prior to being seen.
- **Uninsured Patients:** Payment is expected at the time of service unless prior arrangements have been made with our office.
- **Arrival Time:**
 - If you have **not** completed the paperwork, please arrive **30 minutes early**.
 - If you have completed the paperwork, please arrive **10–15 minutes early**.
- **Medical History:** If you have had any prior surgeries, imaging, or nerve studies related to your upper extremities, please notify our office **before** your appointment.
- **Nursing Home Residents:** Patients residing in nursing homes must be accompanied by a family member or facility staff during their visit.

We appreciate your cooperation and look forward to providing you with excellent care.

Cancellation Policy

1. **New Patients**
 - No-show or cancellations made less than 24 hours in advance will incur a **\$50.00 fee**, which must be paid before rescheduling.
2. **Established Patients**
 - No-show or cancellations made less than 24 hours in advance:
 - **Standard Visit:** \$25.00 fee
 - **New Problem or Over 1 Year (20-minute visit):** \$50.00 fee
3. **Second Opinions (30-minute visit)**
 - No-show or cancellations made less than 24 hours in advance: **\$100.00 fee**
4. **Surgical Appointments**
 - Cancellations made less than 48 hours in advance without valid reason will incur a **\$100.00 fee**. This must be paid before rescheduling surgery or another visit.

Patient Signature

Date

VOLUSIA HAND SURGERY CLINIC, PA
Srikanth Eathiraju, M.D.

FIRST MI LAST
Have you previously been treated by Dr. Eathiraju? ____ Yes ____ No

STREET (Please, include Apt # if applicable)

CITY STATE ZIP CODE

HOME PHONE # CELL PHONE # WORK #

DATE OF BIRTH AGE SOCIAL SECURITY #

PARENT/GUARDIAN NAME (IF UNDER 18 YEARS OF AGE):

FIRST MI LAST PHONE #

EMERGENCY CONTACT: _____ PHONE: _____

Insurance Company: _____ Insured ID# _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security# _____

Preferred Lab: _____

Preferred Pharmacy: _____ Pharmacy Address: _____

*I AUTHORIZE THE PROVIDER TO ELECTRONICALLY PRESCRIBE MEDICATIONS TO MY PREFERRED PHARMACY.

PRIMARY CARE PHYSICIAN REFERRED BY

I hereby authorize the physician indicated above to provide information to insurance carriers concerning this illness/accident and I assign payment of medical benefits to Volusia Hand Surgery Clinic, PA. I also request that authorized medical benefits be made on my behalf to the physician indicated above. I understand that I am financially responsible for all changes whether covered by insurance and for collection fees that may be incurred.

Signature of Responsible Party Date

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

If injury how/place of the injury? _____

Current Problem is the result of () Car Accident () Work Accident () Accident () other

MEDICAL HISTORY

Illness	Yes	No	Notes
<i>High Blood Pressure</i>			
<i>Diabetes Type 1 or 2</i>			
<i>Asthma</i>			
<i>Hepatitis A, B or C</i>			
<i>Thyroid Disease</i>			
<i>Heart Attacks</i>			
<i>Arrhythmia</i>			
<i>Bleeding Disorder</i>			
<i>Seizure Disorders</i>			
<i>Kidney Disease</i>			
<i>Arthritis</i>			
<i>HIV/AIDS</i>			
<i>Other:</i>			

SURGICAL HISTORY

Surgeries or Hospitalization	Physician	Year

MEDICATION LIST

Medications	Dosage/Times per day

ALLERGIES

Last Tetanus Immunization: _____ Cardiologist Name: _____

SOCIAL HISTORY

Smoker? Yes__ No __ Former Smoker? Yes __ No __

How much and what do you smoke? _____

Alcohol use: None __ Occasional __ Moderate __ Heavy __

Marital Status: Single __ Married __ Partner __ Divorced __ Widowed __

Employed: Yes _____ No _____

If yes, what is your occupation? _____

REVIEW OF SYSTEMS

Are you currently having or have you had problems with:

<i>Problem</i>	<i>Yes</i>	<i>No</i>	<i>If Yes, Explain</i>
<i>Chills</i>			
<i>Fatigue</i>			
<i>Fever</i>			
<i>Recent Weight Loss</i>			
<i>Skin Lesions</i>			
<i>Weakness</i>			
<i>Joint Pain</i>			
<i>Swollen Joints</i>			
<i>Stiffness</i>			
<i>Muscle Aches</i>			
<i>Numbness</i>			
<i>Tingling</i>			
<i>Tremors</i>			
<i>Dizziness</i>			
<i>Coldness in Fingers</i>			
<i>Change in Color</i>			
<i>Poor Circulation</i>			
<i>Vision Changes</i>			
<i>Congestion</i>			
<i>Sore Throat</i>			
<i>Shortness of breath</i>			
<i>Wheezing</i>			
<i>Cough</i>			
<i>Chest Pain</i>			
<i>Palpitations</i>			
<i>Irregular Heartbeat</i>			
<i>Recent change in bowel habits</i>			
<i>Diabetes</i>			
<i>Easy bruising</i>			
<i>Blood Clotting Issues</i>			
<i>Other:</i>			

Patient Signature

Date

Reviewed by

Date



386-788-4263(HAND)
www.volusiahandsurgery.com

CONSENTS, AUTHORIZATIONS & ACKNOWLEDGMENTS

CONSENT FOR EVALUATION & TREATMENT

I consent to evaluation and treatment by the providers of Volusia Hand Surgery Clinic, PA, including necessary examinations, diagnostic testing, procedures, and telehealth services as deemed appropriate for my care. I understand that the practice of medicine is not an exact science and no guarantees have been made regarding outcomes.

Patient Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Volusia Hand Surgery Clinic, PA for services rendered. I understand that I am financially responsible for all charges not covered by insurance, including deductibles, co-payments, coinsurance, non-covered services, and fees related to missed appointments or late cancellations. I also understand that I am responsible for collection costs, reasonable attorney fees, and interest allowed by law if my account is referred for collection. I authorize Volusia Hand Surgery Clinic, PA to keep a credit or debit card on file and to charge this card for balances owed including, copayments, deductibles, coinsurance, self-pay balances, supplies, missed appointment fees, late cancellation fees, and any remaining balance after insurance processing.

Patient Signature: _____ Date: _____

CONSENT TO BILL INSURANCE & OBTAIN INFORMATION

I authorize Volusia Hand Surgery Clinic, PA to bill my insurance carrier(s) and to obtain or release medical information necessary to process claims, coordinate care, and facilitate treatment, payment, and healthcare operations, including communication with referring providers, pharmacies, laboratories, imaging centers, and billing or collection services as permitted by law.

Patient Signature: _____ Date: _____

CANCELLATION & NO-SHOW POLICY

I understand that appointments require advance notice for cancellation or rescheduling. Failure to provide required notice may result in applicable cancellation or no-show fees, which are my financial responsibility and may not be covered by insurance.

Patient Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or have been offered a copy of the Notice of Privacy Practices, which explains how my medical information may be used and disclosed, and how I can access my health information.

Patient Signature: _____ Date: _____

CONSENT FOR COMMUNICATION

I consent to be contacted by Volusia Hand Surgery Clinic, PA regarding my care, appointments, and billing matters via phone calls, voicemail messages, mail, email, patient portal, or text message using the contact information I have provided. I understand that standard messaging and data rates may apply.

Patient Signature: _____ Date: _____

ACKNOWLEDGMENT OF OFFICE POLICIES

I acknowledge that I have received, reviewed, or been offered the practice's office policies, including financial policies and patient responsibilities, and I agree to comply with them.

Patient Signature: _____ Date: _____