Volusia Hand Surgery Clinic, PA

Excellence in Hand Care
www.volusiahandsurgery.com

**Tamara R.Clancy, M.D.**
*Board Certified Orthopaedic Surgery*
*Subspecialty Certificate in Surgery of the Hand*

**Srikanth Eathiraju, M.D.**
*Board Certified General Surgery*
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**Sarah E. Henry, M.D.**
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# WELCOME

Thank you for giving us the opportunity to provide your health care. Enclosed you will find forms that need to be completed and brought with you to your appointment. Please include and all x-rays, MRI's, lab work or any testing as well as all of your records from any other doctors you have seen pertaining to the problem you are being seen for today. **Please do not mail!**

**We appreciate your 24 hour advance notice of any cancellation as we have implemented a $50.00 No Show Fee.**

If you've had prior surgery of your upper extremity, please inform our office **PRIOR** to your appointment.

We require some form of identification such as your driver's license, state identification card, etc. If you have insurance, we require that you present your insurance card to us prior to being seen. If you do not have any insurance, you will need to self-pay for the visit. If you're uninsured, payment is expected at the time of service unless prior arrangements have been made with our office.

Patients residing in nursing homes **MUST** be accompanied by family or a staff member when they are brought to the office.

We appreciate your cooperation in this matter and look forward to seeing you in our office.

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Port Orange, FL 32129
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4
Palm Coast, FL 32137
(386) 246-3063

239 N. Ridgewood Ave, Ste 1
Edgewater, FL 32132
(386) 410-4972

211 South Volusia Ave
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# Meaningful Use Patient Form

**Name** _____ **Date** _____

**Email** _____

**Please circle one:**

**Ethnicity:**
Hispanic or Latino
Not Hispanic or Latino
Unknown

**Race:**
American Indian or Alaska Native
Asian
Black or African American
Hawaiian Native or Pacific Islander
Multiple
Other
Unknown
White

**Smoking Status:**
Current every day Smoker
Occasional smoker
Former Smoker
Never Smoker

**Preferred Language** _____

**Primary Care Physician** _____

**Referred by** _____

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**VOLUSIA HAND SURGERY CLINIC, PA**

Tamara Ray Clancy, M.D.
Srikanth Eathiraju, M.D.
Sarah E. Henry, M.D.

**Appointment Date:** _____ **DATE OF INJURY** _____ **Place of Injury** _____

Have you previously been treated by Dr. Clancy, Dr. Eathiraju or Dr. Henry? _____No _____Yes.

_____ _____ _____
**FIRST** **MI** **LAST**

_____
**STREET** (Please include apt. # if applicable)

_____ _____ _____
**CITY** **STATE** **ZIP CODE**

_____ _____ _____
**Phone#** **Age** **Date of Birth**

_____ _____ _____
**Work Phone#** **Ext#** **Social Security#**

_____
**Spouse's Name/Parent's name:** (If child is under 18 years of age)

_____
**Emergency Contact Name and Phone Number**

********PAYMENT IS EXPECTED AT TIME OF SERVICE*******

**Insurance Company Name:** _____

_____ _____
**Policy Holder's NAME** **INSURED ID# AND GROUP #**

_____ _____
**Policy Holder's DATE OF BIRTH** **Policy Holder's S.S. #**

_____
**Pharmacy Name** **Address** **phone #** **Fax #**

_____ _____
**REFERRED BY** **PATIENT PRIMARY CARE PHYSICIAN**

I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. 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 or not 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? _____
How and where did the injuries occur? _____

Current problem is the result of a (n): Check all that apply
( ) Car accident
( ) Work Accident
( ) Accident
( ) Other

| Medications/Supplements/Over-the-counter | Dosage/Times per day | Reason for Medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Last tetanus immunization _____
Are all immunizations up to date? _____ Yes ____ No
If no, which immunizations are due? _____

## Chronic Illnesses (Please Circle)

| | | | | | |
|---|---|---|---|---|---|
| High blood pressure | Yes | No | Diabetes Type 1 or 2 | Yes | No |
| Asthma | Yes | No | Hepatitis A, B or C | Yes | No |
| Tuberculosis | Yes | No | Phlebitis | Yes | No |
| Thyroid disease | Yes | No | Heart Attacks | Yes | No |
| Anemia | Yes | No | Strokes | Yes | No |
| Seizure disorders | Yes | No | Cancer | Yes | No |
| Bleeding disorders | Yes | No | Ulcers | Yes | No |
| Kidney disease | Yes | No | Birth defects | Yes | No |
| Arthritis | Yes | No | HIV/AIDS | Yes | No |
| High Cholesterol | Yes | No | | | |

ALLERGIES

## Past Medical History

| Surgeries/Hospitalizations | Year/Physician | Complications? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Last EKG _____ Cardiologist Name _____ Date of last labwork/Where _____

Have you ever had general anesthesia? Yes____ No____

Have you ever had problems with anesthesia? No____ Yes ____ Explain _____

## Family History

| Member | | Alive | Deceased | Age | Health status/cause of death |
|---|---|---|---|---|---|
| Father | A | D | | | |
| Mother | A | D | | | |
| Sister/Brother | A | D | | | |
| Sister/Brother | A | D | | | |
| Sister/Brother | A | D | | | |

## Social History

Smoker ____No _____ Yes Former Smoker Yes ___ No ____ How much, what do you smoke? ____

Have you used drugs other than for medical reasons in the past 12 months, if so what? _____

Do you drink alcohol? __ No __ Yes, if yes __ monthly or less ___ 2-4x month ___ 2-3x week __ 4 or more x week

Marital Status ___Single ___Married ___ Partner ____ Divorced ___ Widowed ____

N0# of Adults ____ Children ___ in the home.

Level of Education _____ Employed _____Yes ___ No

If yes, what is your occupation? _____

## Review of Systems (Please Circle)

Are you currently having or have you had problems with your:

| | | | | | |
|---|---|---|---|---|---|
| Chills | No | Yes | Prolonged bleeding | No | Yes |
| Fatigue | No | Yes | Muscle aches | No | Yes |
| Fever | No | Yes | Painful joints | No | Yes |
| Weight gain | No | Yes | Swollen joints | No | Yes |
| Weight loss | No | Yes | Cold extremities | No | Yes |
| Diminished vision | No | Yes | Decreased sensation in extremities | No | Yes |
| Weakness | No | Yes | Keloid formation | No | Yes |
| Chest pain | No | Yes | Skin cancer | No | Yes |
| Sputum production | No | Yes | Skin lesions | No | Yes |
| Chest pain with exertion | No | Yes | Loss of strength | No | Yes |
| Dizziness | No | Yes | Memory loss | No | Yes |
| Fluid accumulation in the legs | No | Yes | Seizures | No | Yes |
| Irregular heartbeat | No | Yes | Tingling/Numbness | No | Yes |
| Shortness of breath | No | Yes | Tremor | No | Yes |
| Abdominal pain | No | Yes | Depressed mood | No | Yes |
| Diarrhea | No | Yes | Difficulty sleeping | No | Yes |
| Nausea | No | Yes | Mental or physical abuse | No | Yes |
| Vomiting | No | Yes | Substance abuse | No | Yes |
| Anemia | No | Yes | | | |

Describe all **YES** responses: _____

_____

Patient Signature: _____ Date: _____

Reviewed By: _____ M.D. Date:_____

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# Notice of Privacy Practices Acknowledgement

Patient Name: _____

Date of Birth: _____ SSN: _____

By signing this form, you have acknowledged that we have provided you with our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. We must try to obtain your written acknowledgement on your first date of service after April 14, 2013. If your first date of service with us was due to an emergency, we must try to provide you with our notice and get your written acknowledgement for the notice as soon as we can once the emergency has passed.

Please check all that are true:

( ) I have received the Notice of Privacy Practices (effective 9/23/2013)

_____ _____

Patient or Legal Representative Date

_____

Relationship of Legal Representative

---

For Office Use Only

To be completed only if Acknowledgement is not signed.

1. Was the patient given a copy of the Notice of Privacy Practices?
   ( ) yes ( ) no
2. Please explain why the patient was unable to sign this Acknowledgement and our efforts in trying to obtain the patient's signature:

_____

_____

_____ _____ _____

Signed Name/Title Date

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# IMPORTANT INFORMATION REGARDING INSURANCE BILLING

Our doctors are here to provide you with the best medical care. Their primary concern is your health and well-being, not your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers.

It is very important for you to read your insurance policy very carefully. As we participate with numerous insurance companies and each company has many different plans, we cannot possibly be aware of each patient's particular coverage. You will receive a bill if the service is one that is not covered under your policy. It is important that you are familiar with the benefits and policies of your insurance.

I have read the above and understand that I am responsible for knowing the coverage and benefits of my insurance policy as well as choosing a lab that my insurance company participates with.

_____ _____

Patient Signature Date

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## Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer and **E-FORCSE,** Electronic-Florida Online Reporting Of Controlled Substances Evaluation.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

**I give permission for Volusia Hand Surgery to obtain my medication history from my pharmacy, my health plans, E-FORCSE, and my other healthcare providers.**

Name:_____

Signature:_____

Date:_____

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# Authorization for the Release and/or Discussion of Protected Health Information

Patient Name: _____ SS# ___-__-____ Birth Date ___/___/_____

Authorization

1. I, _____, hereby authorize
2. Name of person or organization: _____

   Street Address : _____

   City, state, zip : _____ Telephone : (  ) _____
3. A. To release and/or discuss the following information

   Complete Record  Outpatient Care  Inpatient Care

   X-Ray Results  Laboratory Results  Treatment Plan Update

   Other _____

   If my record contains the following information, it is also released if *CIRCLED* below:

   Substance Abuse  Mental Health Treatment  HIV Testing or Treatment
4. To _____ of Volusia Hand Surgery Clinic, PA
   3635 South Clyde Morris Blvd Suite 900
   Port Orange, FL 32129

   This information release is at my request for the purpose of legal assistance.
5. Signature :

   I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

   I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

   This authorization expires _____ 6 months _____ one year from today's date, or upon the following specific event: _____.

   I authorize the use of a copy of this form for the disclosure of the information described above.

Signed _____ Relationship _____ Date: ____/____/____

Sent by initials _____

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