TAMPA BAY HAND CENTER

Surgery and Rehabilitation of the Hand & Wrist
Reconstructive Microsurgery

PATIENT INFORMATION SHEET

Patient Name:	Date of Birth:	Date:
Mailing Address:	Social Security:	Date of Injury:
City/State/Zip:	Sex:	Marital Status:
Home Phone #:	Race:	Ethnicity:
Cell Phone #:	Language spoken:	
Email Address:	Emergency Contact Name:	
Employer:	Emergency Phone #:	
Employer Address:	Emergency Relationship:	
Work Phone #:		
Occupation:		

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Insurance Name:	Insurance Name:
Member ID #:	Member ID #:
Group #:	Group #:
Phone #:	Phone #:

SUBSCRIBER INFORMATION

Primary Ins Subscriber Name:		**Secondary Ins Subscriber Name:**	
DOB:	Sex:	DOB:	Sex:
Subscriber SS #:		Subscriber SS #:	
Relationship to Patient:		Relationship to Patient:	
Employer Name:		Employer Name:	
Employer Address:		Employer Address:	
City/State/Zip:		City/State/Zip:	
Employer work phone #:		Employer work phone #:	

GUARANTOR INFORMATION (If different then Patient or Subscriber)

Name:	Date of Birth:
Mailing Address:	Social Security:
City/State/Zip:	Employer:
Home Ph. #: Cell Ph.#:	City/State/Zip:

PRIMARY CARE / REFERRING PROVIDER INFORMATION

Office /Clinic Name:	
Physician Name:	Phone:
Address:	Fax:
City/State/Zip:	

Complete information below, if applicable:

Work Injury: Yes ☐ No ☐	**MV Accident Injury:** Yes ☐ No ☐
Date of Injury:	Date of Injury:
Adjuster Name:	Attorney Name:
Phone #:	Address:
Fax #:	City/State/Zip:
	Phone #:
	Fax #:

Tampa Bay Hand Center

Patient Health History

Patient Name: ______________________________ DOB: ______________ Reason for visit: ____________________________

Allergies ☐ No Know Drug Allergies/NKDA (Please list all medication allergies and type of reaction) ______________________________

____

____

Date of last tetanus vaccination____

Past Medical History ☐ No known medical problems

☐ AIDS/HIV
☐ Anxiety/depression
☐ Arthritis/gout
☐ Asthma/hay fever
☐ Blood clot/DVT
☐ Cancer
☐ COPD/lung problems
☐ Coronary artery disease
☐ Diabetes
☐ Heart disease
☐ Hepatitis type _____
☐ High blood pressure
☐ High cholesterol
☐ Immune disorder
☐ Kidney disease
☐ Liver disorder
☐ Mental illness
☐ Osteomyelitis
☐ Osteoporosis
☐ Pacemaker/defibrillator
☐ Peripheral vascular disease
☐ Seizure disorder
☐ Stroke
☐ Thyroid disease
☐ Ulcers
☐ Other ____

Past Surgical History ☐ No past surgeries (Please list all surgical procedures and month/year of the procedure)____________________________

____

Past Hospitalizations ☐ Yes ☐ No If yes, please state reason and when: ______________________________

____

____

Family History (Please list any family members affected)

Diabetes: ☐No ☐Yes ______________________________ High blood pressure: ☐No ☐Yes ______________________________
Heart disease: ☐No ☐Yes ______________________________ Mental illness: ☐No ☐Yes ______________________________
Cancer: ☐No ☐Yes ______________________________ Coronary artery disease: ☐No ☐Yes ______________________________
Osteoporosis: ☐No ☐Yes ______________________________ High cholesterol: ☐No ☐Yes ______________________________

Height ______ **Weight** ______ **Current Medications** ____

____

____

Pharmacy name and telephone____

Social History

Are you a smoker? ☐ Yes ☐ Never ☐ Former If yes ☐ cigarettes, ____ packs per day for ____ years ☐ cigars ☐ pipe
Do you use chewing/dipping tobacco? ☐ Yes ☐ Never ☐ Former Do you drink alcohol? ☐ Yes, __________ drinks per month ☐ Never
Do you use recreational drugs? ☐ Yes ☐ No

Review of Systems (Do you experience any of the following?)

General
☐ Fever
☐ Chills
☐ Fatigue
☐ Weight gain > 10 pounds
☐ Weight loss > 10 pounds
☐ Appetite change

Hematologic
☐ Bleeding problem
☐ Easy bruising
☐ Enlarged lymph node

Eyes
☐ Recent change in vision
☐ Redness
☐ Eye pain
☐ Double vision

Allergic/Immunologic
☐ Frequent colds/infections

ENT
☐ Hearing loss
☐ Sore throat
☐ Nasal congestion
☐ Runny nose

Endocrine
☐ Cold intolerance
☐ Increased thirst
☐ Increased urination

Respiratory
☐ Chronic cough
☐ Difficulty breathing
☐ Wheezing
☐ Sputum production

Cardiovascular
☐ Chest pain
☐ Leg swelling
☐ Palpitations

Gastrointestinal
☐ Abdominal pain
☐ Heartburn
☐ Nausea/vomiting

Genitourinary
☐ Blood in urine
☐ Urinary retention
☐ Painful urination

Musculoskeletal
☐ Joint pain
☐ Muscle pain
☐ Arthritis
☐ Joint stiffness
☐ Sprain/fracture

Neurological
☐ Numbness/tingling
☐ Seizures
☐ Headaches
☐ Dizziness

Peripheral Vascular
☐ Cold extremities
☐ Painful extremities
☐ Absent pulses in hands
☐ Absent pulses in feet

Psychiatric
☐ Depression
☐ Anxiety
☐ Hallucinations

Skin
☐ Rashes
☐ Itching
☐ Nail changes

Do you have an Advance Directive/Living Will? ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient/Guardian Signature:______________________________________ Date:__________________

HIPAA Notice of Privacy Practices

Tampa Bay Hand Center, P. A.

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

ABOUT THIS NOTICE

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present, or future physical or mental health condition and related health care services and is called Protected PHI Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

How We May Use and Disclose Your Protected Health Information

For Treatment: To provide, coordinate, or manage your healthcare treatment and any related services. We may disclose PHI to other physicians who may be treating you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

For Payment: To seek payment from your health plan, other sources of coverage such as automobile insurer, or from credit card companies you may use to pay for services. For example, your health plan may request or receive information for dates of service, services provided, and the medical condition being treated. **For Health Care Operations:** To support the daily activities of Tampa Bay Hand Center (TBHC). These activities may include, but are not limited to, quality assessment, patient safety, oversight of staff performance, practitioner training, licensing, communication about a product or service, and conducting or arranging other health care related activities. **Business Associates:** To certain companies ("business associates") that provide various services to TBHC (for example, transcription, software maintenance, legal services, and managed care support). The law requires that business associates protect your PHI and comply with the same HIPAA Privacy standards that we do.

Appointment Reminders/Treatment Alternatives/Health Related Benefits and Services: To contact you to remind you that you have an appointment for treatment, or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Public Health Reporting: To public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. **Reporting Victims of Abuse, Neglect, or Domestic Violence:** To government authorities that have the authority to receive such information, include a social service or protective service agency. **Inmates:** To a correctional facility with respect to inmates.

Communicable Diseases: To a person who may be at risk of contracting or spreading a communicable disease. **Health Oversight:** To health oversight agencies legally authorized for audits, investigations, and inspections. This may include health care systems, government benefit programs, civil rights laws, and other government regulatory programs.

Required by Law: To government and other entities as required by federal or state law (including DoD and Military Department regulations). For example, we may be required to disclose your PHI to the Department of Health and Human Services (HHS) investigating HIPAA violations or to a DoD Inspector General conducting other investigations. **Legal Proceedings:** To parties in proceedings of courts and administrative agencies, including in response to a court order or subpoena. **Law Enforcement:** To law enforcement authorities. For example, to investigate a crime involving TBHC or its patients.

Coroners, Funeral Directors, and Organ Donations: To coroners, medical examiners, or funeral directors, and to determine the cause of death or for the performance of other duties. PHI also may be used and disclosed for cadaver organs, eyes, or tissue donations. **Workers' Compensation: T**o the appropriate persons in order to comply with the laws relating to workers' compensation or similar programs. **Minors and Other Represented Beneficiaries:** To parents, guardians, and other personal representatives, generally consistent with the state law. **Verbal Permission:** To family members, or any other persons you identify, that are directly involved in your health care or payment for care. **Uses and Disclosures Requiring Your Authorization:** Disclosure of your PHI, or its use for any purpose other than those listed above, requires your specific written authorization. If you change your mind after authorizing use or disclosure of your PHI, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of PHI that occurred before you notified us of your decision to revoke your authorization.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI. To exercise any of these rights, please submit your request in writing to our Privacy Officer. **Right to Request Access:** You have the right to inspect and obtain a copy of medical or health information that may be used to make decisions about your care. This usually includes medical and billing records.

To inspect or obtain copies, you must sign an authorization form, allowing us to release this information to you. If you request copies of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and obtain a copy in certain, very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Health Science Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. **Right to Accounting of Disclosures:** You have the right to request an "accounting of disclosures" made by TBHC of your medical or health information that occurred in the past six years. The accounting of disclosures will include the date of the disclosure, the name of the entity or person who received the information, and, if known, the address, a brief description of the medical information disclosed, and a brief summary of the purpose of the disclosure. You must request this list in writing. Your request must state a time period that may not be longer than six years prior to the date of the request. The time period may be less than six years. Your request should state in what format you want the list, for example, on paper or electronically. The first list you request within a twelve month period will be provided to you free of charge. For additional lists during this same time period, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. **Right to Amendment:** If you feel an that medical or health information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by TBHC. You must provide a reason for your request. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. We may deny your request if you ask us to amend information that was not created by us, is not part of the information kept by us, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete as it is. If we deny your request to amend the information, we will notify you in writing. **Right to Request Confidential Communications**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work, or that we only contact you by mail at home. To request a confidential communication, you must make your request in writing on a designated form. We will not ask you the reason for your request. We will accommodate all reasonable requests. You must tell how we need to handle your bills for treatment and services. **Right to Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a particular surgery that you have had or visits to a particular doctor or clinic. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, you must make your request in writing. In your request you must tell us what information you want to limit, whether you want to limit our use or disclosure of the information (or both); and to whom you want the limits to apply (for example, disclosures to your spouse).

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Tampa Bay Hand Center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint. To file a complaint with Tampa Bay Hand Center, contact:

Tara Young
Administrator
Tampa Bay Hand Center
13905 Bruce B. Downs Boulevard
Suite B
Tampa, FL 33613
813-978-9494

As required by HIPAA, this facility may not use or disclose your protected health information, except as provided in our Notice of Privacy Practices, without your authorization.

I hereby authorize Tampa Bay Hand Center, P.A. and any of its employees to use or disclose my protected health information (PHI) to the following person(s) or entity:

____

____

____

PHI authorized to be disclosed:____

____

____

Effective dates for this authorization are _______/_______/_______ through _______/_______/_______
This authorization will expire at the end of the above-designated time period.

I understand that information disclosed under this authorization may be disclosed again by the person(s) or entity to which it is provided. It may not be possible to ensure your right to the protection of the privacy of this information once Tampa Bay Hand Center, P.A. disclosed it to another party.

I understand I have the right to:

1. Revoke or terminate this authorization by submitting a written revocation to Tampa Bay Hand Center, P.A. Revocation will not affect previously disclosed PHI.
2. Inspect a copy of PHI being disclosed under this authorization.
3. Refuse to sign the authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this authorization, it will not condition my treatment, payment, enrollment, or eligibility for benefits.

______________________________	______________________	______________
Patient/Patient Representative Signature	Relationship to Patient	Date

Financial Policy

Full payment is due and payable at the time of service. We accept cash, checks, Visa, MasterCard or American Express.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. If your insurance company requires a referral/authorization for treatment, it is your responsibility to provide this to our office prior to being seen. If we are a participating provider with your insurance carrier, or this is a workman's compensation case, we will accept the assignment of benefits and file your insurance for you. However, we do require 100% of your portion of the bill (e.g. co-pay, deductible) be paid at the time of the visit. If your insurance company has not paid your account in full within 45 days from the date of our billing, the balance will automatically be transferred to your responsibility, unless this is a worker's compensation case. If we are not a participating provider for your carrier, we will file the insurance as a courtesy, but full payment will be due at the time service is rendered. If your insurance company pays us after you have paid, we will reimburse you for your payment, minus any portion that is deemed your responsibility by your insurance company. If you require surgery, your insurance benefits will be verified prior to surgery. If this verification indicates that you are responsible for a percentage of the payment, we will collect these fees prior to your surgery date based on the known procedures scheduled to be performed. Your surgery must be preauthorized and approved by your insurance carrier.

Usual and Customary Rates: Our practice charges what is usual and customary for our area. If applicable, based on the type of insurance coverage you have, you may be held responsible for payment of charges regardless of any insurance company's arbitrary determination of usual and customary fees. Be aware that some services may not be covered by your insurance, or may not be considered reasonable or necessary. We will attempt to inform you if we feel a particular service may not be covered. However, there may be times when we will not know that your insurance does not cover a specific item/service.

Missed Appointment: Unless an appointment is cancelled 24 hours in advance, it is our policy to charge a missed appointment fee of $50.00. Please help us serve you better by keeping your scheduled appointments.

I understand and agree to abide by this Financial Policy.

X-ray Handling Policy

If you are bringing x-rays to your appointment that were taken at another facility, these x-rays will become a part of your TBHC office chart and will remain at TBHC. You may take these x-rays from our facility by checking them out with one of our staff members. However, please be aware that these x-rays must be returned to our facility within one week of checking them out.

If you need to obtain a copy of x-rays that were taken in our facility, please notify a staff member at least 72 hours in advance. There will be a $5.00 charge for this service. However, be advised that these x-rays will be provided to you in a digital format and will be yours to keep.

Acknowledgment of Receipt

I acknowledge that I have received the following information and I have read, understand, and agree to abide by its contents (please check all that apply):

- ☐ HIPAA Privacy Notice
- ☐ Financial Policy
- ☐ Standard Authorization for Use and Disclosure of PHI
- ☐ X-ray Handling Policy

Patient/Patient Representative Signature ____________________ Relationship to Patient ____________________ Date ____________________

BayCare
Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange **(BayCare eHX)** is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

❑ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

❑ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

______________________________	______________________________	__________
Printed Name of Patient/Representative	Signature of Patient/Representative	Date

AUTHORITY OF REPRESENTATIVE:

I, ______________________________, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: ______________________________

____

____

Relationship to Patient: ______________________________

BayCare Health System

Electronic Medical Records

Details About Your Health Information in BayCare eHX and the Consent Process:

1. **How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX **only**:
   - To provide you with medical treatment and related services
   - To check whether you have health insurance and what it covers
   - To evaluate and improve the quality of medical care provided to all patients
   - For administrative management of the BayCare eHX
2. **What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access **ALL** of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
   - Substance abuse
   - HIV/AIDS
   - Psychiatric/mental health conditions
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Sexually transmitted diseases
3. **Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
4. **Who May Access Information About You, If You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
5. **Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
6. **Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
7. **Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. **Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.**
9. **Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.