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: _____ *MUST have on file, per office policy.

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

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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:** _____

LANKFORD HAND SURGERY ASSOCIATION
Medical History Information

Medical Conditions: Check those you have at present or have had in the past.

☐ Heart trouble	☐ Diabetes	☐ Hepatitis	☐ Ulcers
☐ High blood pressure	☐ Convulsions	☐ Arthritis	☐ Bleeding Problems
☐ Lung trouble	☐ Tuberculosis	☐ Gout	☐ Kidney/Bladder disease
☐ Light headed spells	☐ Fatigue	☐ Asthma	☐ Cancer
☐ Headaches	☐ Memory loss	☐ Backache	☐ Sleep disorder
			☐ Other _____

List any **major illness** _____

If female, are you pregnant? ☐ If yes, give expected delivery date _____
Any small children? _____ Ages? _____

Surgeries: Check any of the following you have had and give **date**.

☐ Tonsillectomy _____	☐ Gastrointestinal _____	☐ Lungs _____
☐ Appendectomy _____	☐ Hemorrhoids _____	☐ Heart _____
☐ Hysterectomy _____	☐ Hernia Repair _____	
☐ Kidney/bladder repair _____	☐ Hand or upper extremity _____	
☐ Other Procedure & date _____		

Prescription Medications: List those you are currently taking with frequency (e.g. *3/day*, a.m., p.m.).

_____ _____ _____
_____ _____ _____
Non prescription: _____ _____ _____

Are you allergic to any of the following medications?

☐ Penicillin	☐ Sulfa	☐ Codeine	☐ Aspirin	☐ Other _____
☐ Iodine	☐ Novocaine	☐ Xylocaine	☐ Tape	☐ Other _____

Family Medical History: Check if any of your blood relatives have any of the following.

☐ Diabetes	☐ Arthritis	☐ Hemophilia (blood won't clot)	☐ Other _____
☐ Cancer	☐ Heart disease	☐ High blood pressure	☐ Other _____

Personal and **Social History:**
List your occupation. _____
☐ Computer keyboarding Hours per day _____

Sports and **Hobbies:** Check those in which you participate.

☐ Tennis	☐ Golf	☐ Bowling	☐ Weight lifting	☐ Water skiing
☐ Cycling	☐ Computer games	☐ Gardening	☐ Crochet	☐ Hand Crafts
☐ Other _____				

Do you smoke? ◯ No ◯ Yes Number of packs per day _____
Do you drink? ◯ No ◯ Yes ◯ Light ◯ Moderate ◯ Heavy

Preferred Pharmacy :

Name:_____ Address:_____

Patient 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 nay 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

- * In order to be seen at the office today and to continue treatment at this establishment a SSN must be provided to be kept on file in order to hold an individual financially responsible.
- 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: _____