Omni Hand Surgery, PLLC

REGISTRATION FORM

(Please Print)

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Email:

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F

Street address: | Social Security no.: | Cell phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

Preferred Language:_________________________ Race:_____________________________ Ethnicity:____________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No **PRIMARY INSURANCE:**

Identification number | Policy Number

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Co-Payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Omni Hand Surgery, PLLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Omni Hand Surgery, PLLC Financial Policy and Authorizations

We are happy that you selected Omni Hand Surgery, PLLC for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies. Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a onetime electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

____ ________________________________

Patient or Parent/Guardian if Minor Date

Omni Hand Surgery, PLLC

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: ____ Date of Birth: ______________________

Signature: ____ Date:______________________________

***Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact**

Name: ______________________________________ Relationship to Patient: ________________________

Signature: _______________________________________ Date:_______________________________

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:____
Last First Middle

Home Address:____

____

Home Telephone: ____________________________________**Date of Birth:**________________________

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes

- **Discharge Summary** · **Progress/Physician Notes** · **X-Ray Report** · **Pathology Report**
- **History & Physical** · **Nurses Notes** · **EKG/EMG/EEG Report** · **Consult Report**
- **Emergency Report** · **Laboratory Report** · **Operative Report** · **Entire Record**
- Other____

Records for the period (dates) from __________________ to __________________

MY HIGHLY CONFIDENTIAL INFORMATION:
By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about mental health or mental retardation services
- Psychotherapy Notes created by a mental health professional
- Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about sexually transmitted diseases
- Information about alcohol or drug abuse treatment program services
- Information about sexual assault
- Information about child abuse and neglect

RECIPIENT: Name of person or class of persons to whom Omni Hand Surgery, PLLC may disclose my health information:
Address of the recipient or where my health information should be delivered:

TERM: This Authorization will remain in effect:

- From the date of this Authorization until the_____________________
- Until Omni Hand Surgery, PLLC fulfills this request.____
- Until the following event occurs:____
- Other:____

PURPOSE: I authorize Omni Hand Surgery, PLLC to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):[Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]

I understand that once Omni Hand Surgery, PLLC discloses my health information to the recipient, Omni Hand Surgery, PLLC cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Omni Hand Surgery, PLLC may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Omni Hand Surgery, PLLC ; except, however, if my treatment at Omni Hand Surgery, PLLC is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Omni Hand Surgery, PLLC may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Omni Hand Surgery, PLLC Privacy Office at the address listed below. The revocation will be effective immediately upon [Omni Hand Surgery, PLLC receipt of my written notice, except that the revocation will not have any effect on any action taken by Omni Hand Surgery, PLLC in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Omni Hand Surgery, PLLC **to use or disclose my health information in the manner described above.**

____ _____________________________

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

OMNI HAND SURGERY PLLC

____

Signature of Authorized Personal Representative | Relationship to patient | Date

Omni Hand Surgery, PLLC
4500 Hillcrest Road, Suite 160
Frisco, TX 75035
972-947-9395
214-705-1204

Omni Hand Surgery, PLLC
4500 Hillcrest Road, Suite 160, Frisco, TX 75035
(p)972-947-9395 (f) 214-705-1204
www.omnihandsurgery.com

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.

- I authorize Omni Hand Surgery, PLLC to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Omni Hand Surgery, PLLC any information obtained in the adjudication of any claim for services furnished to me by Omni Hand Surgery, PLLC.

- I acknowledge that Omni Hand Surgery, PLLC the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.

- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

- Lan Hua, M.D. is an owner of Texas Institute for Surgery.

- You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than Texas Institute for Surgery.

- You will NOT be treated differently by your physician if you choose to obtain health care services at a facility other than Texas Institute for Surgery.

Please let us know if you have any concern regarding this notice. We welcome you as a patient and value our relationship with you.

Name of Patient/ or Guardian (if Minor): ____

Signature of Patient/or Guardian: ____ Date:__________________

Omni Hand Surgery, PLLC
4500 Hillcrest Road, Suite 160, Frisco, TX 75035
(p)972-947-9395 (f) 214-705-1204
www.omnihandsurgery.com

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Omni Hand Surgery, PLLC to (check all that apply):

☐ Leave a detailed message on voice mail/machine

☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me

☐ Transmit and Receive messages through Patient Portal (Healow or Other) including secure email

☐ None of the above

I further authorize the disclosure of my Patient Health Information (PHI) to the following individuals or family members:

Name:________________________________ Relationship:_________________________

Phone:________________________________

Name:________________________________ Relationship:_________________________

Phone:________________________________

Name:________________________________ Relationship:_________________________

Phone:________________________________

Signature of Patient/or Guardian: _________________________________ Date:________________

OMNI HAND SURGERY PLLC

Omni Hand Surgery, PLLC

4500 Hillcrest Road, Suite 160, Frisco, Texas 75035 Phone: (972) 947-9395 Fax: (214) 705-1204

New Hand Surgery Patient Medical History Form

Patient Name:	**Primary Care Physician:**
Date of Birth:	**Email:**
Gender:	**Pharmacy:**

Are you Right / Left / Ambidextrous handed? (Please circle one)

Please complete this this form and bring it with you to your appointment, we appreciate your time and effort

Problem History Background

What is your main complaint?

Age

How did your main complaint begin (Please give details)?

How long has this been present?

_______Days ______ Weeks _______Months

_______Years

Please Indicate your current pain level

0 1 2 3 4 5 6 7 8 9 10

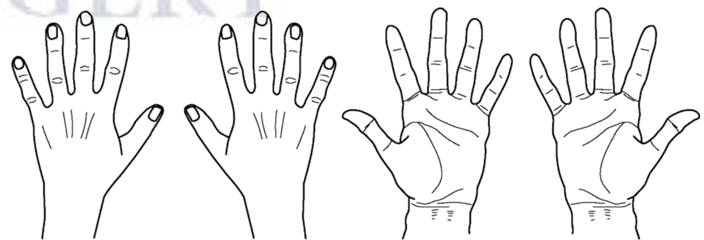
What words best describe how the pain feels?

Sharp Shooting Burning Deep

Stabbing Throbbing Aching Pressure

Dull Tingling Other_________________

OMNI HAND SURGERY PLLC



Left Right Left Right

Please Circle Complaint area in Above Diagram

Treatment History
Have you ever been treated by another Orthopedic or Hand Surgeon? Yes No
Have you had surgery or intended to treat your current complaint? Yes No
Have you had X-ray, MRI, CT scan, or other Radiologic imaging for this problem? Yes No
Have you had an Electromyography or EMG/NCV test to evaluate nerve function? Yes No
Pharmacy name & address:

Omni Hand Surgery, PLLC

Do you have any Allergies? Yes No	Working?
Please List Allergies Below	Job Title
	Married?
Current Medication: (write on back if needed) Yes No	

OMNI HAND SURGERY

Review of Systems (Please Circle) Symptoms Yes No			
Constitutional Normal Chills Night sweats Fever Weight gain Malaise Weight loss	Cardiovascular Normal Chest pain Leg swelling Cyanosis Syncope Heart murmur Irregular Heartbeat/ Palpitation	Metabolic/Endocrine Normal Cold intolerant Hair loss Heat intolerant	Integumentary Normal Contact allergy Skin infections Itchy skin skin-lesion Rash
HEENT Normal Blurred vision Facial Pain Double vision Headache Dysphagia Hearing loss Ear drainage Hoarseness	Gastrointestinal Normal Abdominal pain Heartburn Constipation Jaundice Black tarry stool Loss of appetite Diarrhea Nausea Vomiting	Neurological Normal Difficulty walking Muscle weakness Dizziness Parenthesis Poor Coordination Seizure Memory Loss Tremors	Musculoskeletal Normal Negative, except as noted in HPI and Chief complaint________________ Hematologic Normal Bleeding Bruising
Respiratory Normal Chest Pain Recent Infection Cough Known TB exposure Dyspnea Wheezing	Genitourinary Normal Dysuria Urge incontinence Frequent Urination Urine incontinence Hematuria	Psychiatric Normal Anxiety Depression Insomnia	Immunological Normal Asthma/ Environmental Allergies Bee sting allergies/ Food allergies Contact Dermatitis/ Seasonal Allergies

Social History	
Do you use tobacco? Never Occasional Smokeless (chewing tobacco) Cigarettes,__________/daily Cigars,________/daily	
Do you use Alcohol? Never Rarely Socially Regularly, ___________ drinks/daily	
Have you used recreational (street) drugs? (Drugs within the past 5 years? If yes please list in space below) ____	Yes No
Do you have any history of recreational or street drug addiction?	Yes No

Omni Hand Surgery, PLLC

Past Medical History		YES	NO	
Have you been diagnosed with any of the following conditions at any point in your life? (Please circle)				
AIDS/HIV	Congestive heart failure	GERD	Migraine Headaches	Renal Disease
Alcoholism	COPD	Gout	Multiple Sclerosis	Rheumatoid Arthritis
Alzheimer's	Coronary Artery Disease	Hepatitis	Myocardial Infraction	Scoliosis
Anemia	Crohn's Disease	High Cholesterol	Obesity	Seizure Disorder
Angina	Degenerative joint disease	Hyperlipidemia	Osteoarthritis	Sleep Apnea
Arthritis	Depression	Hypertension	Osteoporosis	SLE
Asthma	Diabetes	Inflammatory bowel disease	Parkinson Disease	Spinal Stenosis
Atrial Fibrillation	Drug Abuse	Juvenile Rheumatoid arthritis	Peptic Ulcer disease	Spondyloarthopathy
Benign Prostatic Hypertrophy	DVT	Kidney Disease	Psoriasis	Thyroid Disease
Cancer	Fibromyalgia	Liver Disease	PVD	Valvular Heart Disease
Cerebrovascular Accident	Gallbladder disease	Lyme Disease	Heart Disease	Pace Maker

Past Surgical History	Yes	NO	Please circle and Date your surgery's	
ACL Surgery	Arthroscopy wrist	Colonoscopy	Laminectomy	Tonsillectomy
Angioplasty	Arthroscopy shoulder	Discectomy	Lasik	Wisdom Teeth Extraction
Angioplasty w/stent	Back surgery	Ear Tubes	Meniscus surgery	Heart Surgery
Appendectomy	CABG	Gastric Bypass	Muscle Biopsy	Child Birth / C-Section
Arthroscopy Ankle	Cardiac Valve Replacement	Hernia Repair	ORIF	Hysterectomy
Arthroscopy elbow	Carpal Tunnel Release	Hip arthroplasty	Pacemaker	Vasectomy
Arthroscopy Hip	Cataract extraction	Hip Replacement	Small bowel resection	
Arthroscopy knee	Cholecystectomy (Gallbladder removal)	Knee Replacement	Thyroidectomy	

Family History YES NO	(Please list Medical problems of your immediate Family)
Relation	Medical Condition
Mother	
Father	
Sibling(s)	Brother(s)_____ Sister(s) _______
Children	Son(s)_______ Daughter(s)_______

I attest that everything stated here is true to the best of my knowledge.

Patient Signature: Date:

I have personally reviewed this form with the patient: Date:

Physician Signature: Date:

Lan Hua, MD
4500 Hillcrest Road, Suite 160, Frisco, TX 75035
(p)972-947-9395 (f) 214-705-1204
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Consent to X-Ray

Date: ___________________________

Patient Name: _________________________________ DOB: ________________________

During your examination, the doctor may feel that x-rays will be necessary in order to diagnose your Condition. In order to perform x-rays on any patient our office requires the patient's consent for such Tests to be performed.

PLEASE CHOOSE ON OF THE FOLLOWING:

_____ I understand that my doctor may need x-rays in order to diagnose my condition and I give Permission to have them performed. I give my permission for x-rays today and all future doctor's Visits with Dr. Lan Hua.

_____ I understand that my condition may require my doctor to take x-rays to further diagnose my Symptoms. I choose not to have x-rays performed at this time and release my doctor of all liabilities.

Signature __________________________________ Date _____________________________

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which can expose my lower torso to radiation, It is possible to injure the fetus.

I have been advised that the 10 days following onset of a menstrual period are generally considered to Be safe for x-ray exam.

PLEASE CHECK THE APPROPRIATE STATEMENT BELOW.

I AM PREGNANT

I AM UNSURE IF I AM PREGNANT BUT WOULD LIKE TO PROCEED WITH THE X-RAY

I AM NOT PREGNANT

SIGNATURE _______________________________________ DATE _____________________________