Center for Hand Surgery

Michelle R. Ritter, MD Orthopaedic Hand Surgery

PLEASE USE BLACK INK

Patient Name____ Date of Birth______________

Address____

Male_____ Female_____ SSN__________-________-___________ First visit? Yes____ No_____

Home telephone (____)_______________ Work (____)_______________ Cell (____)__________________

**E-mail address (required for patient portal) ______________________________*

Occupation/Type of Work:________________________ Full time___ Part time___ Student___ Retired___

CONSENT TO TREATMENT AND ASSIGNMENT OF BENEFITS

I consent to examination and treatment for my problem, and by mutual agreement, diagnostic procedures or other services deemed necessary. I agree to assign the Center for Hand Surgery, Inc. any benefits due me by the insurance carriers for services rendered. Should my benefits be insufficient, I authorize the release of any information required to facilitate payment. I also authorize the release of any information necessary to complete work restriction or disability forms pertinent to my treatment.

Please circle all that apply to your problem:	***Hand R L***	***Wrist R L***	***Forearm R L***	***Elbow R L***	
Finger(s): Left:	***index***	***middle***	***ring***	***little***	***thumb***
Right:	***index***	***middle***	***ring***	***little***	***thumb***

My Primary Care Physician? (PCP): Name______________________________ Phone____________________

Referred by a doctor other than PCP? Name______________________________ Phone____________________

Payment agreement: *I understand that I am responsible for payment to the Center for Hand Surgery Inc and Dr. Michelle Ritter for co-insurance, deductibles, or for any other charges deemed my responsibility by my insurance carrier. If I have no insurance, I agree to pay in full, any services I receive or for whom I am responsible for payment, such as a child, etc.*

Our office is not in the ***MEDICAID*** *network and you may be responsible for payment of any services for you or your dependant.*

IF YOU ANSWER ***YES*** *TO ANY QUESTIONS BELOW, PLEASE FILL OUT THE* ***INJURY FORM*** *ALSO*

Work related? Yes____ No____

Auto Accident? Yes____ No___

Injury Date _____/_____/________

Slip & Fall Yes____ No_____

Attorney involved? Yes____ No____

Attorney Name________________________________

Attorney Phone Nbr_____________________

Work related injuries are covered by Workers Compensation, not Health Insurance. We do not bill Auto Insurance.

My signature indicates that I have read above and fully understand.

Patient or Guardian______________________________ Date______________________

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Center for Hand Surgery, Inc.
Michelle R. Ritter, MD

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*Current privacy regulations (HIPAA) preclude us relaying information to anyone other than our patients, including spouse and children and relatives or friends, unless you authorize it below. This means that if you need to confirm or make an appointment for the office or surgery, **WE WILL NOT TALK TO ANYONE WHO IS NOT ON THIS LIST,** unless you give permission. We cannot discuss test results or prescriptions with family members who call on your behalf, unless you designate them below.*

This authorization is valid until revoked with a new form signed by you. ***Please use black ink***

Name/Relationship	Phone	appts Info	billing info	medical info	surgery info	Rx
Example: Jane Doe /Sister	318-555-5555	✓		✓		✓
1.						
2.						
3.						
4.						

IF YOU DO NOT WISH ANYONE TO HAVE ANY INFORMATION, CHECK THE BOX BELOW.

☐ **I do not authorize the release of information to any other individuals.**
This includes family and friends who call on your behalf.

Please read the privacy statement at www.centerforhand.com or request a copy at appt time.

☐ ***I have received or read a copy of the Notice of Privacy Practices***

In case of a medical emergency while in our office, who would you like us to notify?

Name: ______________________ ***Phone:*** ______________________

Relationship: ______________________

My signature automatically revokes any previous authorizations of this form.

______________________ ____/____/____
PRINT Patient Name Date of birth

______________________ ____/____/____
Signature Date

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PLEASE USE BLACK INK

*Patient Name*____ *DOB*__________/________/__________

*PHARMACY Preference*__________________________ *Phone* _(______)________________

*Location*____

Do you take any prescription or non-prescription medications, vitamins or herbals? Yes______ No______

EXAMPLE: ***Atenolol 25 mg 1/day; blood pressure***

PRESCRIPTION DRUGS	DOSAGE	HOW MANY TIMES PER DAY	REASON

EXAMPLE: Aspirin 81 mg once a day **Vitamin E 500 IU Once a day**

ASPIRIN, VITAMINS, MINERALS, SUPPLEMENTS,	DOSAGE: (mcg, mg, IU)	HOW MANY A DAY?

If female, are you currently pregnant? Yes____No____ How many weeks?________________________

***Please know that we are required to send a copy of your treatment plan to the doctor who referred you to our office for treatment. If the referring doctor is not your physician (e.g. a family friend or employer) please tell the nurse.*

YOU MAY WANT TO BRING YOUR MEDICATION, VITAMINS AND HERBALS TO YOUR APPT.

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