The Minimally Invasive Hand Institute

PATIENT INFORMATION (please print)

Name: _____ D.O.B._____Email: _____

Soc. Sec #_____ Male:___ Female:___ Marital Status:_____ Age: _____

Home Phone ( )_____ Cell Ph ( )_____ Work Ph ( )_____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____Relation: _____ Phone ( )_____

Employer:_____ Position:_____

Work Address:_____ City:_____ State:_____Zip:_____

Primary Care Doctor:_____ Phone ( )_____

Referring Doctor:_____ Phone ( )_____

PRIMARY INSURANCE COMPANY:_____Member ID#_____

Group ID #_____Name Of Insured:_____D.O.B. _____

Claims Mailing Address:_____City:_____State:____ ZIP:_____

SECONDARY INSURANCE COMPANY:_____Member ID#_____

Group ID #_____Name Of Insured:_____D.O.B. _____

Claims Mailing Address:_____City:_____State:____ ZIP:_____

PATIENT MEDICAL HISTORY:

Approximate Height:_____Weight: _____

Major Events, Hospitalizations, and Surgeries:_____

_____

Ongoing Medical Problems: (Diabetes, Blood Pressure): If you are Diabetic have you had an eye exam in the past year (Y/N) _____

Allergies:_____ Family Medical History: _____

Exercise? ___ Daily ___ Weekly ___ Monthly ___ Rarely ___ Never. What Type?_____

History Of Substance Abuse? YES or NO (please circle) What?_____

Smoke Currently? YES or NO (please circle) _____ packs per day for _____ years.

Quit Smoking? _____ This year _____ >1 year _____ >5 years _____Packs per day for _____ years

Drink Alcohol? YES or NO (please circle). How Many? _____ Daily _____Weekly _____Monthly

Have You Ever Had General Anesthesia? YES or NO (please circle)

If Yes, Did You Ever Have Any Problems With Anesthesia? YES or NO (please circle) Describe:_____

REVIEW OF SYSTEMS:

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

(Please describe all "YES" responses)

Eyes Ears, Nose, Throat: YES or NO (please explain below)

_____

Neurological / Nervous system YES or NO (please explain below)

_____

Lungs, Breathing: YES or NO (please explain below)

_____

Gastro Intestinal, Digestion, Reflux, Bowel Movements: YES or NO (please explain below)

_____

Heart, Blood Pressure, Cholesterol: YES or NO (please explain below)

_____

Endocrine, Liver, Kidneys, Blood Sugars, Thyroid: YES or NO (please explain below)

_____

Reproductive / Genitourinary / Prostate: YES or NO (please explain below)

_____

CURRENT MEDICATION LIST:

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

Medication:_____ Dose:_____mg. How Often:_____

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Privacy Regulations oh the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

I, _____, give permission to **The Minimally Invasive Hand Institute** to:
____ **Obtain** the following protected health information ***FROM***:
____ **Disclose** the following protected health information ***TO:***

_____
Name of Provider

_____
Address

(_____)_____(_____)_____
Telephone Number Fax Number

"Health records" are records describing my health history, symptoms, examinations, test results and diagnoses. Treatment and any plans for future care or treatment. I understand this information is to be used serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.

I request the following person: _____ relation:_____
to be able to obtain access to my healthcare information and to discuss my care with the doctor and staff.

This authorization expires 1 year (one year) from the date of signature. I understand I have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosure. The Notice Of Privacy Practices describes specific uses of your Protected Health Information.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to the **Privacy Officer** at **The Minimally Invasive Hand Institute** at 8960 W. Tropicana, Las Vegas, NV 89147. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____
Signature of Participant or Personal Representative

_____
Date

_____
Printed Name of Participant/Personal Representative

_____
Description of Personal Representative's Authority

Please forward my Protected Health Information to:

The Minimally Invasive Hand Institute

9080 W. Post RD, Suite 200
Las Vegas, NV 89148

(702) 739-4263 Phone
(877) 739-3590 Fax

MEDICATION USE AGREEMENT

I, _____, understand that I have pain that has not been adequately controlled with other medications and that my function is limited by pain. I understand that the intent of the medicine is to increase my ability to do more, though the medication is unlikely to eliminate the pain. ***I agree to take the medicine ONLY as prescribed***. I will not take any sedatives, alcohol or other pain medicines without the prior approval of my doctor.

I further acknowledge that the **medication will be prescribed ONLY by Dr. Sorelle or Dr. Hanna** and only according to the agreed-upon schedule. **Prescriptions will be provided ONLY during regularly scheduled appointments**. Refills will NEVER be provided by telephone. I will not seek or accept any medication for pain other than those provided by my doctor. "Medications for pain" includes prescriptions from other doctors, medications borrowed or accepted from family or friends, and any illicit or street drugs.

Medication refills will be provided as written prescriptions only. **No refills will be given prior to the next scheduled appointment**. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one day's working notice or two (2) no-show appointments may constitute grounds for immediate termination under this agreement.

I understand that my doctor is under no obligation to provide these medications to me, and that he or she reserves the right to discontinue these medications at any time. If I refuse, the medications will be stopped. I also understand that lost or stolen medications will not be refilled under any circumstance, except in the case of presentation of a valid police report detailing the medication theft. It is the patient's sole responsibility to guard their medications and take them as directed. This includes keeping the medications out of reach of children.

I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep all appointments when my doctor refers me. My doctor will send a report of my care and a copy of this agreement when a referral is made.

In addition to these above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medication from a source other than Dr. Sorelle or Dr. Hanna at The Minimally Invasive Hand Institute.
2. I give, sell or in any way distribute prescribed medications to any other person(s).
3. I in any way attempt to forge or alter a written prescription.
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents a danger to my well-being or safety.
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I agree to fill my prescriptions only at the pharmacy listed below. If I change pharmacies, I will contact my doctor's office immediately and provide them with the name, address and phone numbers of the new pharmacy. ***Under NO circumstances will I obtain medications from more than one pharmacy at a time***. In order to verify appropriate medication use, my doctor's office will provide my chosen pharmacy will a copy of this agreement. I understand that any alteration or changes in my medication type or dosage will require a new written agreement.

Pharmacy Name: _____ Pharmacy Cross Streets: _____

Pharmacy Address: _____

Pharmacy Telephone: ( )_____ Pharmacy Fax: ( ) _____

Number Of Pills Prescribed: _____ Frequency Of Appointments: _____days.

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my doctor and his or her practice.

_____

Patient Signature Date

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

(please read and initial each)

I hereby authorize medical treatment for the above-named patient and fully acknowledge that all office visits are on a cash basis, and will be paid in full at the time of service, unless otherwise contracted by my insurance. I further understand that my insurance policy is a contract between my insurance company and myself and that I am responsible to Dr. Jonathan Sorelle, M.D. or Kenny Hanna, M.D., aka The Minimally Invasive Hand Institute, for any fees not covered by my insurance company.

x_____ *I understand that my insurance will be billed as a courtesy to me. I also understand that it is my responsibility to follow up with my insurance company 30 days from the date of service, to make sure they are processing my claims****. Any claims not paid within 90 days will be my responsibility.***

x _____ **As of June 1, 2010 ALL FORMS NEEDING COMPLETION BY THIS OFFICE WILL BE SUBJECT TO A $35 FEE**. Please complete all information to the best of your knowledge.

x _____ *I hereby authorize the filing of any insurance claims in force and the direct payment to Dr. Sorelle, M.D. or Dr Hanna M.D., of any amounts on my claims. I further authorize the office of Dr. Sorelle, M.D. or Dr Hanna to release any and all pertinent medical records necessary to facilitate insurance billing or medical care and authorize the creditor or higher agent to make any employment or insurance verification and release of all information needed to process claims. I hereby authorize Dr. Sorelle, M.D. or Dr. Hanna, M.D. to receive, mail, fax or email my records to another physician or medical facility in the course of my diagnosis and treatment.*

Signature: _____ Date: _____

Financial Policy

Thank you for choosing The Minimally Invasive Hand Institute! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Any balance older than 30 days is the patient's responsibility.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Administrator.

How May I Pay?
We accept payment by cash, check, through our CareCredit option, Discover, VISA, and MasterCard.

Do I Need A Referral or Pre-certification?
If your insurance plan requires a referral authorization from your primary care physician or a pre-certification from your insurance, you need to contact your primary care physician or insurance company to be sure it has been obtained. If we have not received an authorization prior to your arrival at the office your appointment will be rescheduled.

Which Plans Do You Contract With?
The Minimally Invasive Hand Institute accepts most major insurance plans. It is always best for you to contact your insurance company prior to your appointment to see if we are participating providers.

What Is My Financial Responsibility for Services?
It is your responsibility to verify that the physicians and/or facility in which you are seeking treatment are an authorized provider under your insurance plan. A current provider listing should be made available to you by your employer, insurance company or insurance company's web-site.

What If I Have Billing or Insurance Questions?
The Minimally Invasive Hand Institute is supported by a staff of dedicated professionals. Our office staff has the expertise to assist in all financial matters, relieving the patient of burdensome paperwork.

Your financial responsibility depends on a variety of factors, explained below:

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, “regular” insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, x-ray, injection, and other charges at the time of office visit.	Accept your initial payment and file an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Accept your initial payment and file an insurance claim as a courtesy to you.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Accept your payment in full and file an insurance claim as a courtesy to you.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Accept your initial payment and file an insurance claim as a courtesy to you.
Medicare	If you have Regular Medicare, and have not met your $162 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit after your Medicare deductible has been met. If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% copay is requested at the time of the visit.	Accept your Medicare deductible (if applicable) and file the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO	All applicable copays and deductibles at the time of the office visit.	Accept your initial payment and file an insurance claim as a courtesy to you.
Worker’s Compensation	If we have verified the claim with your carrier No payment is necessary at the time of the visit. If we are not able to verify your claim Your appointment will need to be re-scheduled.	Schedule your appointment after your worker’s compensation carrier had called ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
Worker’s Compensation (Out of State)	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
Occupational Injury	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.

Surgery
If your physician recommends surgery, your surgery will be scheduled by your physicians' nurse or assistant. He/She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Billing Department will require a pre-surgical deposit in the amount of $500.00 to go towards your surgery co-payment, deductible or any other amount deemed the patient's responsibility by your insurance carrier. After your insurance company has processed your surgery claim, any amount remaining as a credit balance will be refunded to you.

What if My Child Needs to See the Physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

What if I missed my appointment to see the Physician?
We understand that on rare occasions, issues may arise causing you to miss your appointment without the ability to notify our office prior to your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office to have it rescheduled.

Our highly skilled Physicians are committed to your well-being and have reserved time just for you. Patients that miss more than one appointment, without notifying our office prior to the scheduled appointment, are subject to a $20.00 missed appointment fee. This fee will be waived if notification to our office is made within 24 hours AND the appointment is rescheduled for a later date.

If a scheduled surgery date is canceled, there will be a $500 cancellation fee. This fee will be waived if we are contacted 48 hours prior to 9:00am of the scheduled day of surgery.

_____

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service, are my responsibility.

In addition, I understand that there will be a $50 collection fee to any accounts that have been sent to a collection agency, in addition to any attorney fees.

I authorize The Minimally Invasive Hand Institute *to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to* The Minimally Invasive Hand Institute.

_____	_____	_____
Date	**Signature**	**Printed Name**

The Minimally Invasive Hand Institute
9080 W. Post RD, Las Vegas, NV 89148
5300 Highway 95, Suite M, Fort Mojave, AZ 86426
(702) 739-4263 Phone (877) 739-3590 Fax

The Minimally Invasive Hand Institute

9080 W. Post RD, Suite 200, LV, NV 89148 Office (702)739-4263 Fax (877)739-3590
5300 Highway 95, Suite M, Fort Mojave, AZ 86426

Supplies/Durable Medical Equipment Waiver

As a service to our patients at The Minimally Invasive Hand Institute, we offer certain supplies and durable medical equipment to assist in your recovery. However, your insurance carrier may not consider the item deemed as medically necessary or many not considered a covered benefit. Therefore, we will bill Durable Medical Equipment (DME) but not supplies. Please ask the Physician, prior to purchase, if the item you are purchasing is a DME or supply.
At The Minimally Invasive Hand Institute we contract with several insurance carriers. Regardless of what your insurance plan that you are on, it is our goal to offer quality of medical treatment that you deserve. Therefore, we are requesting that you sign this waiver recognizing that your insurance will not be billed if you are purchasing a supply. If you are purchasing a piece of DME, our office will file your claim with the included item; however, if the item is not a covered benefit you will be held financially responsible. Please keep in mind; items are not returnable according to federal health guidelines. If the item is defective, we will exchange the item.

Beneficiary's Acknowledgement
I have been notified by The Minimally Invasive Hand Institute policy of Supplies and Durable Medical Equipment. If I purchase a DME and it is denied by my insurance carrier, I understand that I will be held financially responsible.

I also understand that this purchase is not returnable unless it is defective and I will be given a replacement product.

_____ _____
Patient/Guardian's Signature Date

_____ _____
Witness Signature Date

Patient's Name: Insurance id#

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that your insurance may not pay for the item(s) or services(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered item and services when your insurance company rules are met. The fact that the insurance may not pay for a particular item or service does not mean that you should not receive it. There may be good reason your doctor recommended it. Right now, in your case, **Insurance may not pay for.**

Items or Service:

IMPLANTS TO INCLUDE, BUT NOT LIMITED TO: PLATES, SCREWS, CLIPS WIRE, ANCHORS, BONE MATRIX & PRP INJECTIONS. (PROTEIN RICH PLASMA)

Because: THESE ARE SPECIFIC EXCLUSIONS FOR SOME INSURANCE POLICIES. SOME INSURACE COMPANIES REQUIRE A MINIMUM AMOUNT BEFORE THEY WILL PAY, OTHER PLACE CAP ON THE AMOUNT THEY WILL PAY.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why insurance may not pay.
- Ask us how much these items or services will cost you (Estimated Cost: $50-$1200) in case you have to pay for them yourself or through other insurance.

Please choose ONE option. Check ONE box Sign and Date your choice.

Option 1. YES. I want to receive these items or services.

I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay you will refund to me any payment I made to you that are due to me. If my insurance denies payment, I agree to be personally and full responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my insurance companies' decision.

Option 2. NO I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that insurance won't pay. I also understand with this choice that my surgeon will be notified and my procedure may need to be cancelled.

_____ _____

Date **Signature of patient or person acting on patient's behalf**