

Cy-Fair Hand & Wrist Surgical Associates, PA

Date: _____

Last Name _____ First Name _____ MI _____

Gender (M or F) _____ Age _____ Marital Status _____

Address _____

City _____ State _____ ZIP _____

Home # _____ Work # _____ Cell # _____

Date Of Birth _____ Social Security No. _____

E-Mail _____ Occupation _____

Employer _____ Address _____

City _____ State _____ ZIP _____ Tel Phone # _____

Primary Insurance :	Secondary Insurance :
Ins Name/ WC _____	Ins Name/ WC _____
Subs ID / Claim # _____	Subs ID / Claim # _____
Group # _____	Group # _____
Insurance Phone _____	Insurance Phone _____
Subscriber _____	Subscriber _____
Subscriber DOB _____	Subscriber DOB _____
Subscriber SSN _____	Subscriber SSN _____
Adj Name/ Ph/ Fx _____	Adj Name/ Ph/ Fx _____

Emergency Contact _____

Telephone _____ Work _____ Cellphone _____

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Dr. Fiore all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____	_____
Signature of Patient, Parent, Guardian, or Representative	(Date)
_____	_____
Please print name of Patient, Parent, Guardian, or Representative	Relationship to Patient

Reason for visit: _____

Referred By: _____ Phone #: _____

For Office Use Only

Appt date/time: _____

Co-Pay:	Ded:	Ded Met:
Co-Ins:	OOP:	OOP Met:

Pt. Last Name _____ First Name _____ MI _____

Allergies : Please list any medications that you are allergic to and what happens when you take them ?

Medications : Please list ALL Medications that you take (including Aspirin, Motrin, Supplements, etc.)

Review of Systems : Please fill in the oval completely as shown here for **any** of the conditions that you have/had:

- | | | | |
|--|--|--|--|
| <input type="radio"/> Fever | <input type="radio"/> Dizziness | <input type="radio"/> Fingertip cold intolerance | <input type="radio"/> Rash |
| <input type="radio"/> Depression | <input type="radio"/> Fingertip ulcers | <input type="radio"/> Blood in stool | <input type="radio"/> Productive cough |
| <input type="radio"/> Shortness of breath | <input type="radio"/> Difficulty urinating | <input type="radio"/> Constipation | <input type="radio"/> Weight loss |
| <input type="radio"/> Tingling/numbness in feet or hands | <input type="radio"/> Chest pain | <input type="radio"/> Diarrhea | <input type="radio"/> Weight gain |
| <input type="radio"/> "Just don't feel well" | <input type="radio"/> Joint aches: Which joints? _____ | | |

Family History : Please fill the oval completely as shown here for **any** medical problems in your immediate family (Mother, Father, Sister, Brother):

- | | | |
|---|--------------------------------------|---|
| <input type="radio"/> Reaction to anesthesia | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> Bleeding problems | <input type="radio"/> Heart problems | <input type="radio"/> Diabetes |
| <input type="radio"/> HIV/ AIDS | <input type="radio"/> Lung Disease | <input type="radio"/> Cancer : What type? _____ |
| <input type="radio"/> Other diseases that run in the family ? _____ | | |
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Cy-Fair Hand & Wrist Surgical Associates, P.A.
Office & HIPPA (Privacy) Policies

We reserve the right to charge a \$25 fee for all missed appointments or appointment cancellations made less than 24 hours of the scheduled appointment.

We reserve the right to charge a \$50 fee for any paperwork that utilizes an extensive period of the doctor's time outside of your regular visit to be completed. You will be notified prior to the completion of the paperwork if this fee applicable. All fees must be paid prior to completion. This does not apply to basic school or work excuses, or Worker's Compensation (DWC-73) forms. Worker's Compensation claims/bills that are denied for any reason will become the responsibility of the patient.

ALL PATIENT DEDUCTIBLES AND CO-INSURANCE FEES MUST BE PAID PRIOR TO ANY SCHEDULED OFFICE VISIT OR SURGERY, NON-PAYMENT WILL RESULT IN CANCELLATION OF YOUR APPOINTMENT OR SURGERY.

I have read and I am aware of the above policies. PATIENT INITIALS _____

PRIVACY (HIPPA) POLICY

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment. Please let us know with whom we may share information.

May we discuss your case with your employer or personal/Worker's Comp Insurance company? YES NO

Name

Relationship

Name

Relationship

By signing below, I authorize the persons listed above to receive my protected health information. I understand that I may revoke this authorization at any time. My revocation must be in writing to Cy-Fair Hand & Wrist Surgical Associates, P.A. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal and state privacy protection regulations).

My initials indicate that I have received copies of the following information:

Privacy Policy PATIENT INITIALS _____

Patient Bill of Rights PATIENT INITIALS _____

Cy-Fair Surgery Center: Notification of Physician Financial Ownership PATIENT INITIALS _____

Print Name

Patient Signature or Guardian

Date

Patient Bill of Rights

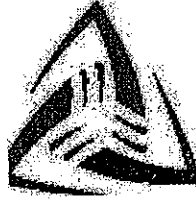
This Facility adopts and affirms as policy the following rights of patient/clients who receive services from our facility. The facility will provide the patient or the patient's representative verbal and written notice of such rights in advance of the date of the procedure in accordance with 42 C.F.R. § 416.50, and these patient rights will be posted within the facility in the facility's waiting room(s).

The patient rights are as follows:

- Treatment without discrimination as to age, race, color, religion, sex, national origin, political belief, or handicap. It is our intention to treat each patient as a unique individual in a manner that recognizes their basic human rights.
- Considerate and respectful care including consideration of psychosocial, spiritual, and cultural variables that influence the perceptions of illness.
- Receive, upon request, the names of physicians directly participating in your care and of all personnel participating in your care.
- Obtain from the person responsible for your health care complete and current information concerning your diagnosis, treatment, and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information shall be made available to an appropriate person in your behalf.
- Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations. This information shall include as a minimum an explanation of the specific procedure or treatment itself, its value and significant risks, and an explanation of other appropriate treatment methods, if any.
- The patient may elect to refuse treatment. In this event, the patient must be informed of the medical consequences of this action. In the case of a patient who is mentally incapable of making a rational decision, approval will be obtained from the guardian, next-of-kin, or other person legally entitled to give such approval. The facility will make every effort to inform the patient of alternative facilities for treatment if we are unable to provide the necessary treatment.
- The facility will provide the patient or patient representative with the facilities policies and description of the State health and safety laws on advance directives, and upon request, refer you to resources for general information on how to formulate an advance directive, including where to obtain the official State advance directive form, and appointing a surrogate to make health care decisions on your behalf, to the extent permitted by law. Access to health care at this facility will not be conditioned upon the existence of an advance directive.
- Privacy to the extent consistent with adequate medical care. Case discussions, consultation, examination and treatment are confidential and should be conducted discreetly.
- Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party payment contract.
- A reasonable response to your request for services customarily rendered by the facility, and consistent with your treatment.
- Expect reasonable continuity of care and to be informed, by the person responsible for your health care, of possible continuing health care requirements following discharge, if any.
- The identity, upon request, of all health care personnel and health care institutions authorized to assist in your treatment.
- Refuse to participate in research or be advised if your personal physician and/or facility proposes to engage in or perform human experimentation affecting his/her care or treatment. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services
- Upon patient request, examine and receive a detailed explanation of your bill including an itemized bill for services received, regardless of sources of payment.
- Know the facility's rules and regulations that apply to your conduct as a patient.
- Be advised of the facility grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge date is premature. Notification of the grievance process includes: who to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Complaint or criticisms will not serve to compromise future access to care at this facility. Staff will gladly advise you of procedures for registering complaints or to voice grievances including but not limited to grievances regarding treatment or care that is (or fails to be) furnished.
- Access and copy information in the medical record at any time during or after the course of treatment. If patient is incompetent, the record will be made available to his/her guardian.
- Expect to be cared for in a safe setting regarding: patient environmental safety, infection control, security and freedom from abuse or harassment.
- Receive care, free of restraints unless medically reasonable issues have been accessed and pose a greater health risk without restraints.
- Participate in the development, implementation and revision of his/her care plan.

Complaints

- Complaints may be directed to the following: Cy-Fair Surgery Center Contact: Sonja Christmas or Cindy Kelley at 11250 Fallbrook Drive Houston, Tx. 77065 Phone 281-955-7194. Dr. Fiore's Office Contact: Cecilia Fiore: Phone 281-970-8002
- Complaints may be directed to the following State Agency: Texas Department of Health Hotline at 1-888-973-0022
- Web site for the Medicare Beneficiary Ombudsman: www.medicare.gov or 1-800-633-4227 or www.cms.hhs.gov/center/ombudsman



CY-FAIR SURGERY CENTER

NOTICE TO PATIENTS: Physician Financial Ownership

We are required by Federal law to notify you that physicians hold financial interests or ownership in this ASC. We are required by 42 C.F.R. § 416.50 to disclose this financial interest or ownership in writing and in advance of the date of the procedure you are schedule to receive at the facility. A list of physicians who have a financial interest in this ASC is listed below:

- | | |
|-------------------------|-------------------------|
| 1. Dr. Ata Ahmad | 10. Dr. Farhina Imtiaz |
| 2. Dr. Arturo Bravo | 11. Dr. Kent Johnson |
| 3. Dr. Michelle Bricker | 12. Dr. Thang Le |
| 4. Dr. Oanh Bui | 13. Dr. James Liu |
| 5. Dr. Richard Day | 14. Dr. John Roff |
| 6. Dr. Kendrick Dennis | 15. Dr. Kristi Sumpter |
| 7. Dr. Nicholas Fiore | 16. Dr. Khoa Tran |
| 8. Dr. Scot Frost | 17. Dr. Matt Warnock |
| 9. Dr. Raka Gohel | 18. Dr. Michele Wiggins |

NOTICE TO PATIENTS: Policy for Advanced Directives

Please note that our Facility's policy on Advanced Directives is that Life sustaining efforts will be initiated and maintained on all patients.

If you would like information on developing Advanced Directives, the following website can assist you and includes a description of the State's health and safety laws:

<http://www.uslivingwillregistry.com/forms.shtml>

Additionally, upon request, we will provide you with official State advance directive forms.

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can obtain this information. **PLEASE REVIEW CAREFULLY.**

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments. Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying services. An example would be your health plan may request and receive information on dates of service, services provided and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the daily activities of Cy-Fair Hand and Wrist.

As an example, information on the services you received may be used to support financial reporting, projections, and steps for evaluating and promoting quality care.

Legal. Your health information may be disclosed to public health agencies as required by law. An example would be if we are required to report some communicable diseases to the state's public health department.

Other uses and disclosures requiring authorization. Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information

Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

Cy-Fair Hand and Wrist Duties

We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Revising Privacy Practices

We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

For more information about HIPAA:

US Department of Health and Human Services
202-619-0257
Toll Free: 1-877-696-6775