



GRABOW HAND TO SHOULDER CENTER

Ryan J. Grabow, MD

Board Certified, Hand to Shoulder Specialist



Insurance Information & Medical Records Release

Patient Name: _____	Social Security Number: _____ - _____ - _____
Address: _____	City: _____ State: _____ Zip: _____
Employer: _____	Employer Phone: _____ - _____ - _____
Occupation: _____	Date of Birth: ____/____/____ Age: ____
Home Phone: _____ - _____ - _____	Single:___ Married:___ Widowed: ___ Divorced:___
Cell Phone: _____ - _____ - _____	In Case of Emergency notify: _____
Work Phone: _____ - _____ - _____	Emergency contact phone1: _____ - _____ - _____
Spouse/Companion: _____	Emergency contact phone2: _____ - _____ - _____

Authorization for Insurance Payment

Insurance Carriers

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physician(s). I agree that this authorization will cover all medical services until revoked by me. I agree that a photocopy of this form may be used in place of the original. I understand that I am responsible for the charges that occur as a result of my medical treatment.

Signature (patient or responsible party)

Date

Insurance Information of Primary Card Holder

Primary Insurance Type: _____	Policy #: _____
Name: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female SS#: _____
Birth Date: ____/____/____	Patient's Relationship to Primary Card Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Employer: _____	Employer Phone: _____ - _____ - _____
Secondary Insurance Company: _____	Policy #: _____
Does your insurance require you to obtain referral's for specialty visits: ___Yes ___ No	

Medical Lifetime Authorization (MEDICARE PATIENTS ONLY)

I authorize any holder of medical or other information about me to release to The Social Security administration and Health Care Financial Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in lieu of the original and request payment of medical insurance benefits whether to myself or to the party who accepts assignments. Regulations to Medicare assignment of benefits apply.

Signature (patient or responsible party)

Date



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Financial Policy

The following is a statement of the financial aspect of your medical treatment which must be read and signed prior to any treatment rendered.

INSURANCE: We accept assignment of insurance benefits. However, it is your responsibility to call your insurance company to determine the status of your benefits with respect to the amount of your deductible, co-payment, or whether you need pre-authorization, etc. Please notify our office of any changes in your health insurance carrier or status. Your insurance policy is a contract between you and your insurance company, but we will bill your insurance company as a courtesy to our patients.

PAYMENT: We do require your co-payment, co insurance or deductible be paid at the time of service. We accept cash, check, Visa or MasterCard and Discover. If payment arrangements are necessary, we will require that a Financial Disclosure be completed to determine the eligibility for our payment plan. (All of the above information is confidential and will not be disclosed). If an account has been placed with our collection agency for lack of regular payments or ignored attempts for collections, all future office visits must be paid 100% at the time of service. The same policy will be required for all accounts that have filed bankruptcy.

RETURNED CHECK POLICY: Any patient whose check is returned from the bank will be assessed a \$25 return check fee in addition to replenishing the cash funds for the check. Once a check is returned we will no longer accept a check, only credit card, debit or cash funds for services rendered to you as a patient. By signing this financial policy you have acknowledged our policy and agree with its terms.

CASH PAY: Patients who do not have insurance or choose not to use their insurance, will be considered "cash Pay". A payment of \$200.00 will be due at the time of their first visit upon arrival. If the visit charges are less than the \$200.00 deposit, the balance will be refunded at check out. If the visit is more than \$200.00 due to additional services (Xrays, injections, casts etc), the additional funds will be due and collected before you leave the office. All subsequent visits will be charged based on our cash pay payment policy if paid in full at time of service.

BALANCE DUE: As a courtesy to our patients all balances for services rendered do not incur interest if paid in full within sixty (60) days. If a balance remains after sixty (60) days, a finance charge of 15% APR will be incurred on a monthly basis and applied to a balance greater than \$5.00 until paid in full. Minimum charge will be \$1.00 monthly on remaining balances. All balances that show no payments after ninety (90) days or are default of an arranged payment plan will be submitted to collections.

AGREEMENTS: In consideration of the treatment provided, the undersigned agrees:

1. That payments under my medical insurance benefits are made to my physician and that he may provide information concerning my treatments or that of my minor child to my health insurance carriers or its agent.
2. That I agree to pay for all collection fees, attorney fees, court costs, and filing fees, including charges that may be assessed by our collection agency to pursue collections of my account.
3. That I have read the Financial Policy above and understand and accept the terms of this Financial Policy.

Print Patients Name

Date

Signature of Patient or Responsible Party

Date

Signature of Witness

Date



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Patient History

Name: _____ Age: _____ Occupation: _____
 Your Medical Doctor: _____ Who referred you? _____
 Are you Right or Left Handed? Right Left
 Hobbies, Sports, or Musical Instruments: _____
 Email address: _____ (your email address is never shared or sold)
 Would you like to receive Dr. Grabow's *FREE* quarterly email newsletter – **Shoulder to Finger Tips** which provides advice on avoiding common Hand to Shoulder Problems? Yes No

HOW DID YOU LEARN ABOUT DR.GRABOW? (please check all that apply)

<input type="checkbox"/> My Doctor	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Friend/Family: _____
<input type="checkbox"/> Embarq Phone Book	<input type="checkbox"/> Google search	<input type="checkbox"/> Newspaper
<input type="checkbox"/> Community Talk or Event	<input type="checkbox"/> Yahoo.com	<input type="checkbox"/> DexKnows.com
<input type="checkbox"/> Angie's List	<input type="checkbox"/> Vitals.com	<input type="checkbox"/> Yellowpages.com
<input type="checkbox"/> Kudzu.com	<input type="checkbox"/> Superpages.com	<input type="checkbox"/> Insiderpages.com
<input type="checkbox"/> Casino Employees Magazine	<input type="checkbox"/> Senior Citizens Magazine	<input type="checkbox"/> _____

WHAT ARE WE YOU SEEING YOU FOR TODAY? (check all that apply)

My: Finger Hand Wrist Forearm Elbow Arm Shoulder Other: _____
What side? Right Left Both **Which Fingers:** Thumb Index Long Ring Little
What is your complaint or injury? (check all that apply)
I have pain in my: Finger Hand Wrist Forearm Elbow Arm Shoulder
I broke a bone in my: Finger Hand Wrist Forearm Elbow Arm Shoulder
I have a problem with: Numb fingers Finger sticks Lump on wrist Stiff Shoulder
 Rotator Cuff tear Shoulder Arthritis Tendonitis Stiff Fingers
Not Listed, Describe it here: _____

HOW DID YOUR PROBLEM DEVELOP? (check all that apply)

What caused your problem?
 I don't know A fall Work injury Sports injury Car accident Motorcycle accident
Describe what happend: _____
When did it first start? Date: ____/____/____ I don't remember, developed gradually
How long has it been a problem? weeks: ____ months: ____ years: ____
Other important information: _____



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WHAT TREATMENTS HAVE YOU ALREADY TRIED? (check all that apply)

- | | | | |
|---|---|------------------------------------|---|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Stopped sports | <input type="checkbox"/> Ice | <input type="checkbox"/> Anti-inflammatory medication |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Bracing | <input type="checkbox"/> Injection | <input type="checkbox"/> Other treatment: _____ |

What medical providers have you seen for this problem?

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> My regular doctor | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Orthopedic surgeon | <input type="checkbox"/> Hand surgeon |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Physical therapist | <input type="checkbox"/> Massage therapist | <input type="checkbox"/> Other: _____ |

What testing have you had for this problem?

- | | | | |
|--------------------------------------|---|-----------------------------------|--|
| <input type="checkbox"/> Xrays | <input type="checkbox"/> MRI | <input type="checkbox"/> Cat Scan | <input type="checkbox"/> Nerve Study (EMG/NCV) |
| <input type="checkbox"/> Blood drawn | <input type="checkbox"/> Other testing: _____ | | |

Medical History

LIST ALL MEDICAL PROBLEMS, CURRENT AND PREVIOUS (check all that apply) No medical problems

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Blood Clot (DVT/PE) | <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Trigger Finger | <input type="checkbox"/> Hepatitis: A B C |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Alcohol dependency | <input type="checkbox"/> Drug dependency | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other: _____ | | |

Surgical History

LIST ALL PREVIOUS SURGERIES (check all that apply, please indicate year) No prior surgeries.

- | | | |
|---|---|--|
| <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Colon resection _____ | <input type="checkbox"/> Gall bladder removed _____ |
| <input type="checkbox"/> Coronary stents _____ | <input type="checkbox"/> Prostate surgery _____ | <input type="checkbox"/> Mastectomy _____ |
| <input type="checkbox"/> Coronary Bypass _____ | <input type="checkbox"/> Valve replacement _____ | <input type="checkbox"/> Knee Replacement _____ |
| <input type="checkbox"/> Knee replacement _____ | <input type="checkbox"/> Hip replacement _____ | <input type="checkbox"/> Shoulder Replacement _____ |
| <input type="checkbox"/> Wrist arthroscopy _____ | <input type="checkbox"/> Knee arthroscopy _____ | <input type="checkbox"/> Shoulder arthroscopy _____ |
| <input type="checkbox"/> Hip fracture surgery _____ | <input type="checkbox"/> Wrist fracture surgery _____ | <input type="checkbox"/> Shoulder fracture surgery _____ |
| <input type="checkbox"/> Trigger finger _____ | <input type="checkbox"/> Ganglion cyst removal _____ | <input type="checkbox"/> Carpal Tunnel R L _____ |
| <input type="checkbox"/> C-section _____ | <input type="checkbox"/> D & C _____ | <input type="checkbox"/> Appendectomy _____ |
| <input type="checkbox"/> Tubal ligation _____ | <input type="checkbox"/> Tonsilectomy _____ | <input type="checkbox"/> Vasectomy _____ |

Other: _____

Do you have any surgical implants? Pacemaker Plates & Screws Rods Bullets/Shrapnel

Other implants: _____ Location of implants: _____



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Social History

I am currently: Single Married Divorced Do you have children? No Yes, How many: _____

Do you care for an elderly parent or disabled individual? No Yes: _____

If you are single, do you have roommates? No Yes

Do you drive? No Yes What type of transmission? Automatic Stick shift Disability modified

Do you drink alcohol? I do not drink I drink on occasion:(daily weekly monthly at holidays)

How many drinks do you have when you drink? Beers: _____ Wine: _____ Liquor: _____

Do you use tobacco? No I quit, Time since quitting: _____ years months weeks

Yes, I smoke cigarettes: Packs per day: _____ Yes, I smoke cigars: Cigars / week: _____

Yes, I dip / chew: Tins/Pouches per week: _____

Medication and Allergy History

LIST ALL MEDICAL ALLERGIES? I have no allergies

I have allergies to the following medications: Penicillin (reaction: rash can't breathe I don't know)

Sulfa drugs other medications: _____

I have allergies to the following: latex tape iodine x-ray dye shellfish metals

MEDICATIONS

In order to provide the safest and most effective medical care, Dr. Grabow needs a complete list of the following:

1. Medications prescribed by a physician you are taking on a daily, weekly, or as needed basis
2. Over-the-counter medications and any form of supplement, homeopathic, or herbal remedy you are taking.

Please list the medications and supplements you are currently taking:

**If you have a list on paper already, we can make a photocopy.*

I am **not** currently taking any medications

1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	



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Request for Release of Medical Records & Tests

I _____, hereby request that copies of my medical records and tests be released to:

Grabow Hand to Shoulder Center

Ryan J. Grabow, MD
2780 Horizon Ridge Parkway, Suite 30

FAX: 702 – 478 – 5492

(To whom records and xrays are being released)

Physician's Office & Hospital

I authorize Grabow Hand to Shoulder Center; Ryan J. Grabow, MD, LTD; or their agents to obtain my medical records from other physicians or parties. A photocopy of this form may be used in lieu of the original.

Please include all the following to be released:

() The entire medical record () Medical data related to: _____

() All Radiology tests: () Xrays () Cat scan () MRI () Bone Scan () Other: _____

() Specific dates of service: _____

Patient Name: _____
Last First MI

Date of Birth: _____ Social Security No. _____

Affirmation of Release:

By signing below I give my permission to release my medical records and studies to the Grabow Hand to Shoulder Center. I understand that this release is valid for up to one year from the date of signature and I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. Any revocation or refusal to sign this authorization will not prevent medical treatment or payment. I understand that a revocation must be sent in writing

Signature of Patient / Guardian / Legal Representative

Date Signed

*HIPPA Regulations require that the following statements be present on this release: The information disclosed may be subject to redisclosure by recipient and no longer protected. This authorization may be revoked at any time.



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ACCIDENT INFORMATION

If you were in an auto accident or slip and fall please complete this form.

Date of Injury: _____

Type of Accident: Auto Slip and Fall Dog Attack Assault

Event details: _____

Place of Accident: _____

Your Auto Insurance Coverage: _____

Name of Auto Insurance: _____

Insurance Adjuster Name: _____

Claim # _____

Billing Address for Claims: _____

Phone # _____ Fax # _____

Other party Insurance: _____

Insurance Adjuster Name: _____

Phone # _____ Fax # _____

Attorney Name: _____ Firm Name: _____

Attorney/Firm Address: _____

Phone # _____ Fax # _____

Contact Person: _____