GREATER CHESAPEAKE HAND SPECIALISTS, P. A.

Christopher L. Forthman, M.D.
James P. Higgins, M.D.
Peter C. Innis, M.D.
Michael A. McClinton, M.D.
J. Russell Moore, M.D.

Providing Quality Care for Problems of the Upper Extremity:
Hand, Wrist, Elbow, Arm and Shoulder

1400 Front Ave., Suite 100 • Lutherville, Maryland 21093
(410) 296-6232 (800) 870-4263 • Facsimile (410) 296-0311
www.chesapeakehand.com

Michael S. Murphy, M.D.
Keith A. Segalman, M.D.
Raymond A. Wittstadt, M.D.
Neal B. Zimmerman, M.D.

REGISTRATION FORM

PATIENT NO.

Failure to complete all spaces on the form will result in delays.
If a section does not apply to you, write "N/A"

DATE:

PATIENT NAME: LAST	FIRST	M	☐ MALE ☐ FEMALE

BIRTH DATE:	AGE:	SSN:	HOME PHONE:

STREET ADDRESS:	CITY:	STATE:	ZIP:

ADDITIONAL CONTACT INFORMATION - CELL PHONE NUMBER:	E-MAIL ADDRESS:

PATIENT'S EMPLOYER:	ADDRESS:	WORK PHONE:

IS YOUR VISIT DUE TO:

1. A WORK RELATED CONDITION: ☐ YES ☐ NO
2. AN AUTOMOBILE ACCIDENT: ☐ YES ☐ NO ***(IF YES, COMPLETE SECTION "PIP" BELOW)***
3. A LIABILITY CASE: ☐ YES ☐ NO

} HAVE YOU FILED A CLAIM? ☐ YES ☐ NO

ATTORNEY:	ADDRESS:	PHONE:

WORKER'S COMPENSATION INFORMATION

NAME OF EMPLOYER AT TIME OF CLAIM:	ADDRESS:	PHONE:
NAME OF COMPENSATION INSURANCE COMPANY:	ADDRESS:	PHONE:
ADJUSTER'S NAME:	CLAIM NO.:	DATE OF ACCIDENT/ONSET OF CONDITION:

▼ INSURANCE INFORMATION ▼

PIP (PERSONAL INJURY PROTECTION) INSURANCE (COMPLETE ONLY IF IN AUTO ACCIDENT)

NAME OF AUTOMOBILE INSURANCE:	ADDRESS:	PHONE:
INSURED'S NAME:	ADJUSTER'S NAME:	
CLAIM NO.:	DATE OF ACCIDENT:	STATE WHERE ACCIDENT OCCURRED:

PRIMARY HEALTH INSURANCE (CAREFIRST, MEDICARE, HMO's, ETC.)

NAME OF INSURANCE COMPANY:		ADDRESS:	
POLICYHOLDER NAME:		POLICY HOLDER'S DATE OF BIRTH:	RELATIONSHIP TO PATIENT:
POLICYHOLDER'S SOCIAL SECURITY NO.:	POLICY NO.:	GROUP NO.:	POLICY HOLDER'S EMPLOYER:

SECONDARY HEALTH INSURANCE (CAREFIRST, MEDICARE, HMO's, ETC.)

NAME OF INSURANCE COMPANY:		ADDRESS:	
POLICYHOLDER NAME:		POLICY HOLDER'S DATE OF BIRTH:	RELATIONSHIP TO PATIENT:
POLICYHOLDER'S SOCIAL SECURITY NO.:	POLICY NO.:	GROUP NO.:	POLICY HOLDER'S EMPLOYER:

OFFICE USE ONLY	CO-PAY:	REFERRAL NEEDED: ☐ YES ☐ NO

To Be Completed By ALL Patients ▼ **MEDICAL INFORMATION** ▼ *To Be Completed By ALL Patients*

PATIENT'S NAME: | AGE:

REASON FOR VISIT: | DATE OF INJURY/ONSET:

IF INJURY, BRIEFLY DESCRIBE DETAILS OF HOW INJURY OCCURRED:

PHYSICIAN REQUESTING CONSULTATION:

REQUESTING PHYSICIAN'S ADDRESS:

PRIMARY CARE PHYSICIAN: | SEND REPORT: ☐ YES ☐ NO PHONE: _____ FAX: _____

PRIMARY CARE PHYSICIAN'S ADDRESS:

OCCUPATION: | ARE YOU: ☐ RIGHT HANDED ☐ LEFT HANDED

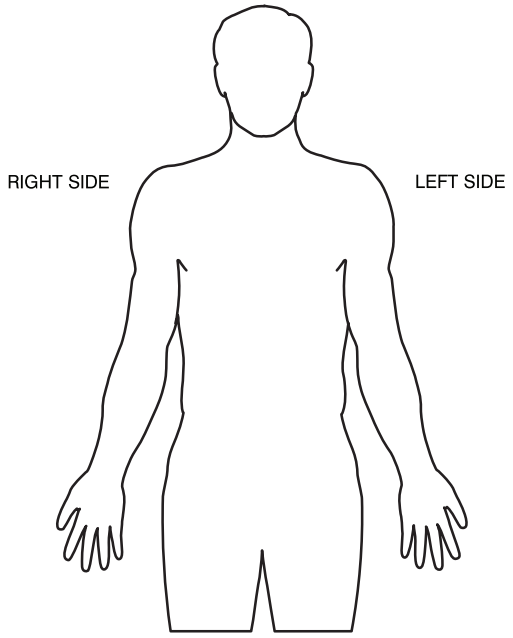
ALLERGIES: | ARE YOU ALLERGIC TO LATEX: ☐ YES ☐ NO

MEDICATIONS: LIST CURRENT MEDICATIONS

MEDICAL CONDITIONS: ✓ FOR YES

HEART DISEASE	☐	GI DISORDER	☐	HEPATITIS	☐
HIGH BLOOD PRESSURE	☐	REFLUX	☐	HIV	☐
IRREGULAR HEART BEAT	☐	GU DISORDER	☐	TUBERCULOSIS	☐
PACEMAKER	☐	DIABETES	☐	LYME DISEASE	☐
BLOOD CLOTS	☐	THYROID DISEASE	☐	ARTHRITIS	☐
BLOOD THINNERS	☐	CANCER	☐	GOUT	☐
SLEEP APNEA	☐	ANXIETY DISORDER	☐	OSTEOPOROSIS	☐
LUNG DISEASE	☐	DEPRESSION	☐	NEUROLOGIC DISORDER	☐

CIRCLE AREA(S) OF INJURY OR ILLNESS ON DIAGRAM



SURGERIES:

FAMILY HISTORY – LIST ANY MEDICAL CONDITIONS OF IMMEDIATE FAMILY:

SOCIAL HISTORY: DO YOU SMOKE? ☐ YES ☐ NO HOW MUCH _____ | DO YOU DRINK ALCOHOL? ☐ YES ☐ NO HOW MUCH _____ | DO YOU EXERCISE? ☐ YES ☐ NO

EMERGENCY CONTACT:

NAME: | CONTACT #:

RELATIONSHIP TO PATIENT:

SIGNATURE: _____ DATE: _____

Greater Chesapeake Hand Specialists, P.A.

Authorization and Financial Responsibility

I hereby authorize Greater Chesapeake Hand Specialists, P.A. to furnish information to insurance companies concerning my illness and treatment. I hereby irrevocably assign to Greater Chesapeake Hand Specialists, P.A. all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered, or denied, by my insurance company. A photocopy of this authorization shall be considered as effective and valid as the original. I also understand that if my workmen's compensation claim has not been approved, you are required to file with my private insurance carrier.

I authorize Greater Chesapeake Hand Specialists, P.A. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

In the event that my account is referred to an attorney for collections, I agree to pay for reasonable attorney fees and court costs. I further agree that all legal proceedings shall occur in Baltimore County, Maryland.

Signed at Greater Chesapeake Hand Specialists

_____ _____

Patient/Legal Guardian Signature Date

If financially responsible/insured person is other than patient/legal guardian, please sign below:

_____ _____

Financially Responsible/Policy Holder's Signature Date

_____

Relationship to Patient

GREATER CHESAPEAKE HAND SPECIALISTS, P.A.
PATIENT CONSENT
USES AND DISCLOSES REQUIRING AN OPPORTUNITY FOR THE INDIVIDUAL TO AGREE OR OBJECT

Patient's Name:_____ Date: _____

Patient's Social Security Number: _____ Date of Birth: _____

By signing this form, I consent to GCHS' use and disclosure of my Protected Health Information for the purposes of *treatment, payment and/or health care operations* as defined in the Privacy Notice of GCHS.

_____ _____
Signature of Patient or Legal Representative Witness

I acknowledge receipt of the Notice of Privacy Practices. _____
Patient's Initials

CONTACT INFORMATION

1) HOW SHOULD WE CONTACT YOU?
You have the right to request us to contact you in a certain way or at a certain place. Please let us know if you have a contact preference, e.g. cell phone, home, work:

_____
_____

2) TO WHOM MAY WE DISCLOSE (Person to whom GCHS or LSC MAY USE OR DISCLOSE PHI*)

Name: _____
Relationship to patient: _____
Address: _____ Home Tel: _____
_____ Work Tel: _____
Other contact information, e.g. cell phone _____

3) TO WHOM MAY WE NOT DISCLOSE *(*Person to whom GCHS or LSC MAY NOT USE OR DISCLOSE PHI*)

Name: _____
Relationship to patient: _____

*PHI: Protected Health Information

PRIVACY NOTICE
OF
GREATER CHESAPEAKE HAND SPECIALISTS, P.A.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the legal duties and privacy practices of Greater Chesapeake Hand Specialists, P.A. ("GCHS") to protect the privacy of your individually identifiable health information or *Protected Health Information (PHI)*, as that term is defined under the Health Insurance Portability and Accountability Act of 1996 *("Information")*, in providing for your medical treatment and needs.

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. GCHS is required to follow the terms of this Notice until it is replaced. GCHS may make changes to the terms of this Notice at any time. Upon your request, GCHS will provide you with a copy of its current Notice. GCHS reserves the right to make the changes apply to your *Information* maintained by GCHS before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits GCHS to use and disclose your *Information*.

Purposes for which GCHS May Use or Disclose Your Medical Information with your Consent

GCHS may request your consent for the use and disclosure of your I*nformation* for *treatment, payment or health care operations* as described below.

- ***Treatment*.** We will use and disclose your *Information* to provide, coordinate, or manage your health care and any related services. We may disclose your *Information* to physicians, therapists, or other health care providers who are treating you or assisting in your diagnosis, treatment or recovery. For example, GCHS may provide your *Information* to the physician who referred you to GCHS. In addition, we may disclose your *Information*, from time to time, to another health care provider, including a physician, specialist or laboratory who, at the request of your physician, becomes involved in your care.

- ***Payment*.** Your *Information* will be used and disclosed, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. In order to obtain approval for a surgical procedure, your plan may require that your relevant *Information* be disclosed to them. If more than one third party payer may be responsible for payment for your health care, we may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for health care services rendered to you by other providers.

- ***Health Care Operations*.** We may use or disclose, as needed, your *Information* in order to support our delivery of health care services. We may call you by name in our waiting room area when your physician or other health care provider is ready to see you. We may use or disclose your *Information*, as necessary, to contact you to schedule an appointment or remind you of your appointment. These uses and disclosures are necessary for us to run our operations properly and make sure that our patients receive quality care. Other examples of these activities include, but are not limited to, quality assessment activities, employee review activities, and licensing. We may combine *Information* about more than one patient, to, for example: evaluate the performance of our staff in caring for patients; decide what additional services we should offer; or analyze the effectiveness of new treatments. Certain patient safety considerations may also cause us to use and disclose your health information.

We may share your *Information* with third party "Business Associates" who perform various services for or on behalf of GCHS. Examples of Business Associates who GCHS may share your *Information* with in order to conduct its day-to-day operations include billing services, transcription services, record retention and destruction entities, attorneys, accountants, auditors or other professional consultants. Whenever an arrangement between a Business Associate and us involves the use or disclosure of your *Information*, we will have a written contract that contains terms that will protect the privacy of your *Information.*

- ***Health Care Services***. Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent

Your *Information* may be disclosed to a family member, friend or other person designated by you or as designated by the law, if you verbally agree.

Uses and Disclosures With Your Authorization

Except as provided below, your *Information* will not be used for any non-routine purposes unless you give GCHS your written authorization to do so. GCHS may request your authorization to use and disclose your *Information* for research purposes. If you give GCHS written authorization to use or disclose your *Information* for a purpose that is not described in this Notice, then, with certain exceptions, you may revoke it in writing at any time. Your revocation will be effective for the I*nformation* GCHS maintains, unless GCHS has taken action in reliance of your authorization.

Uses and Disclosures Without Your Consent, Opportunity to Agree or Disagree or Authorization

- As required by law;
- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- For research purposes in limited circumstances;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To an organ procurement organization in limited circumstances;
- To avert a serious threat to your health or safety or the health or safety of others;

Uses and Disclosures Without Your Consent, Opportunity to Agree or Disagree or Authorization (continued)

- To a governmental agency authorized to oversee the health care system or government programs;
- To federal officials for lawful intelligence, counterintelligence and other national security purposes;
- To public health authorities for public health purposes; and
- To appropriate military authorities, if you are a member of the armed forces.

Your Rights

You may make a written request to GCHS to do one or more of the following concerning your *Information*:

- Put additional restrictions on GCHS' use and disclosure of your *Information.*
- Communicate with you in confidence about your *Information* by a different means or at a different location than GCHS is currently doing.
- See and get copies of your *Information*.
- Correct your *Information.*
- Receive a list of disclosures of your *Information* that GCHS, and its Business Associates, make for certain purposes for six (6) years prior to your request (after April 14, 2003), with certain exceptions permitted by law, including exceptions for disclosures made to you or made pursuant to your authorization.
- Send you a paper copy of this Notice if you receive this Notice by e-mail or on the internet.

If you want to exercise any of these rights described or require further information about GCHS' privacy practices, please contact GCHS at the address below. Please know that in certain instances, GCHS does not have to agree to your request. GCHS will give you the necessary information and forms for you to complete and return. GCHS will charge you a fee of $.60 per page for copying any documents requested in accordance with "your rights" as listed above.

Complaints

If you believe your privacy rights have been violated by GCHS, you have the right to complain to GCHS or to the Secretary of the U.S. Department of Health and Human Services. You may file a written complaint with GCHS by contacting the Privacy Official at the address below. An individual must file a complaint within 180 days of when he knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. GCHS will not retaliate against you if you choose to file a complaint.

Contact Office

To request additional copies of this Notice or to receive more information about GCHS' privacy practices or your rights, please contact our Privacy Official:

Contact Office: Greater Chesapeake Hand Specialists, P.A.
Telephone: 410-296-6239 Fax: 410-296-7363
E-mail: PattyL@chesapeakehand.com
Address: 1400 Front Avenue, Suite 100, Lutherville, MD 21093