BADIA
Hand to Shoulder Center

Patient Information

First Name: _____ **M.I.:** _____ **Last Name:** _____
Date of birth: _____ **Sex:** ☐ male ☐ female **Social Security:** _____
Address: _____
Street City State Zip Code
Permanent Address (if different from above)**:** _____
Street City State Zip Code
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
E-mail Address: _____

Workers Comp or Auto Insurance Company Name: _____
Address for claims: _____
Street City State Zip Code
Adjuster Name: _____ Phone: _____

Primary Insurance Company Name: _____ Phone: _____
Policy number: _____ Group number: _____
Policy holder name: _____ Date of birth: _____
Social security number: _____ Relationship to patient: _____

Secondary Insurance Company Name: _____ Phone: _____
Policy number: _____ Group number: _____
Policy holder name: _____ Date of birth: _____
Social security number: _____ Relationship to patient: _____

Primary Care Physician: _____ Phone _____
Emergency Contact: _____ Relationship: _____
Phone: _____ Address: _____
Do you have an Advance Directive? (living will, health care surrogate) ☐ yes ☐ no

I do hearby consent to any medical care which is deemed advisable or necessary by my healthcare provider and grant authority to Badia Hand to Shoulder Center, to administer and perform all examinations, treatments, diagnostic procedures and surgeries needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance, and any other health plan, are assigned to Badia Hand to Shoulder Center. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as the original.

Patient Signature: _____ Date: _____

Patient name: _____

BADIA
Hand to Shoulder Center

Financial Policy

This is an agreement between Badia Hand to Shoulder Center, as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money order, cashier's check, Visa, Master Card, Discover, and American Express. No post-dated checks will be accepted. We collect copay, coinsurance and any deductible at the time services are rendered.

Insurance: Insurance is a contract between you and your insurance company. It is your responsibility to understand your insurance plan benefits. In order to file your claims, we require a legible copy of the front & back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information including primary and secondary insurance for claims submissions PRIOR to receiving services. All copay, coinsurance and deductibles are due at the time services are rendered.

Failure to provide complete and accurate insurance information may result in the entire bill being your responsibility. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Once the claim is processed, if there is any additional liability, you will be billed accordingly.

Services unexpectedly denied by your insurance plan due to retroactive terminations, Coordination of Benefits (other health insurance that may be primary) denials, payment offset due to retroactive termination, failure to respond to your insurance plans with requested information or failure to provide our office with any new health insurance changes are all reasons patients may be responsible for payment of services received in our office. All of these circumstances are beyond our control. It is the patient's responsibility to resolve any issues that arise with their eligibility and benefits.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file with your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have. We highly recommend you contact your insurance carrier and check your available benefits before care is received from our office. Do not assume that you will not owe anything, even if you have more than one insurance policy.

Self-pay accounts: Self pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If you have health insurance and there is a discrepancy regarding your coverage or eligibility, the patient will be considered self-pay unless otherwise proven.

Appointment Cancellation Policy: If you need to cancel your appointment, please notify our office within at least 24 business hours. Failure to do this keeps us from scheduling other patients that need to be seen. A fee will be charged for appointments not cancelled with 24 hours advanced notice. This includes cancelled appointments, rescheduled appointments, and missed appointments (no-shows). The fee for this is $50.00. This fee will have to be paid at the time of your rescheduled appointment; if no appointment is rescheduled, you will be billed for this fee. The provider will not see you until this fee has been paid.

Collection fee: A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee currently of $25.00 for any checks returned by the bank. Payment made on a returned check must be made in cash or by a money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Unsubstantiated credit card disputes will incur a $35.00 administrative fee.

Disability forms, insurance forms, and other forms: There will be a fee of $75.00 for the completion of medical forms. Payment is due at the time the form is dropped off. Please allow 5-7 business days for these to be completed.

Copying of records: There is a fee of $1/page for the first 25 pages and 25 cents for every page thereafter for copies of your records to be sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. Copies of images (x-ray, MRI) are available by CD and are subject to a $10.00 fee per disc.

Responsible party (if not the patient): _____

Patient Signature: _____ Date: _____

Patient name: _____

Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of Badia Hand to Shoulder Center Notice of Privacy Practices as required by federal law.

Patient Consent for use and disclosure of Protected Health Information

I authorize the office Badia Hand to Shoulder Center to disclose protected health information to the following:

Name and relationship of person(s) authorized to receive information:

_____

_____

_____

Telephone Messages

Please circle one:

I **do / do not** authorize the office of Badia Hand to Shoulder Center to leave telephone messages regarding my protected health information on the voicemail or answering machine.

Consent to photograph

I authorize Badia Hand to Shoulder, LLC and its affiliates to take pictures of my (or my child's) medical or surgical procedure(s) and condition(s) and to the use of such pictures for treatment, scientific, educational or research purposes.

By signing below, I certify that I have read, understand, and agree to all four Notices above.

Patient Signature: _____ Date: _____

Patient name: _____

Mutual Agreement

Dr. Alejandro Badia, M.C., and Badia Hand to Shoulder Center (collectively labeled "physician") agree to provide treatment to: _____ ("patient"). The Physician takes pride in being able to extend a greater degree of
Patient's name
privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patient's best interest. Accordingly, Physician agrees not to provide medical information for the purposes of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician – his practice, expertise, and/or treatment – on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the tie of creation (prior to publication) of the commentary.

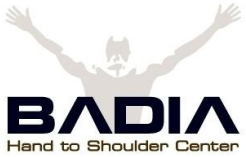
This agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

Patient Signature: _____ Date: _____

Patient name: _____



Agreement as to Resolution of Concerns

"I", "Patient/Guardian" shall be understood to mean _____. "Physician" shall be understood to
Patient's name

mean Alejandro Badia, M.D. / Badia Hand to Shoulder Center.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agrees not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

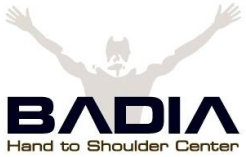
Furthermore, should a meritorious medical malpractice cause or cause of action be initiated or pursued, I and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these witnesses will be members in good standing of, and adhere to the guidelines and/or code of conduct, defined for expert witnesses by the ASSH and AAOS.

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient Signature: _____ Date: _____

Patient name: _____



Credit Card Authorization

Successful treatment depends not only on the skill of your physician, but on the commitment, attendance and efforts of you, the patient, as well. At Badia Hand to Shoulder Center we pride ourselves on working with our patients in a timely manner so that the treatment process has the most minimal impact on our patients' precious time. In addition, your timely attendance is important to facilitating short wait times and optimal patient flow.

The staff at Badia Hand to Shoulder Center is committed to accommodating your scheduling needs. In return, Badia Hand to Shoulder Center expects 24 hours' notice prior to rescheduling or canceling an appointment. Any appointments cancelled or rescheduled without 24 hour notice will be assessed a $50.00 fee. This fee also applies to appointments in which a patient fails to attend or call. Our office has set this time aside to accommodate the schedule, and without proper notice, we are unable to provide the opportunity to another patient who may have requested the same time.

For workers compensation patients, should your workers compensation insurance refuse to pay this fee due to your negligence, you will be responsible for this fee.

I have read the cancellation policy and understand that I will be responsible to pay a cancellation/no show fee of $50.00 as indicated above. I authorize Badia Hand to Shoulder Center to charge a one-time fee of $50.00 to the credit card on file for each appointment missed. I understand that I will not be informed prior to this fee being charged to my account. I understand that if I give at least 24 hours advanced notice of cancelling an appointment, this fee will not be charged from my account. I understand that if I do not provide my credit card information to Badia Hand to Shoulder Center, I will still be responsible for this fee, and will be billed for this fee.

Patient Signature: _____ Date: _____

BADIA HAND TO SHOULDER CENTER

NEW PATIENT MEDICAL HISTORY FORM

Patient name: _____ Weight:_____
required for minors

Race: ☐ African American ☐ Asian ☐Caucasian Native American/Alaskan ☐ Pacific Islander
☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Answer

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Preferred pharmacy: _____
Name Phone number

Referral source: ☐ Doctor: _____ ☐ Other (i.e. google): _____

Chief Complaint

Dominant hand (hand you write with): ☐ Right ☐ Left ☐ Ambidextrous

Description of symptoms: ☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness ☐ Other: _____

Body part affected:

Shoulder	☐ Right	☐ Left	Thumb	☐ Right	☐ Left
Upper arm	☐ Right	☐ Left	Index	☐ Right	☐ Left
Elbow	☐ Right	☐ Left	Middle	☐ Right	☐ Left
Forearm	☐ Right	☐ Left	Ring	☐ Right	☐ Left
Wrist	☐ Right	☐ Left	Little	☐ Right	☐ Left
Hand	☐ Right	☐ Left			

Pain radiates from/to (i.e. from elbow to forearm): _____

History of Present Illness

1. Is your problem the result of an injury or accident? ☐ No injury ☐ Injury ☐ Injury at work
   ☐ Auto accident ☐ Sports injury ☐ Prior surgery
   When did the condition begin? _____
   mm/dd/yyyy
2. Are you represented by an attorney? ☐ Yes ☐ No
   Attorney name: _____
   Will there be any legal actions with respect to this problem? ☐ Yes ☐ No
3. Have you had a problem like this before? ☐ Yes ☐ No
   If so, please describe: _____
   _____
4. Have you been seen in an ER or urgent care for this problem? ☐ Yes ☐ No
   Treating ER/Urgent Care: _____ Date: _____
5. Do the symptoms wake you from sleep?
   ☐ Yes ☐ No
6. Please describe the symptoms:
   ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting

Patient name: _____

History of Present Illness (continued)

7. What is the timing of the symptoms?
   ☐ Constant ☐ Intermittent (comes and goes)
8. Is the problem getting better or worse?
   ☐ Getting better ☐ Getting worse ☐ Unchanged
9. What makes the symptoms worse?
   ☐ Twisting ☐ Moving ☐ Lying in bed ☐ Athletics ☐ Gripping ☐ Lifting ☐ Reaching overhead
10. Are there any other symptoms associated with this problem?
    ☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness/tingling ☐ Stiffness ☐ Clicking
    ☐ Locking ☐ Popping ☐ Weakness
11. Briefly describe how your symptoms began or how the injury occurred: _____
    _____
    _____
    _____

Prior Testing/Treatment

Have you had any prior tests for this problem?

☐ None ☐ X-rays ☐ MRI ☐ CT ☐ Nerve testing (NCV/EMG)

Have you had any prior treatment for this problem ☐ Yes ☐ No

Type of treatment	**Status of symptoms after treatment**			**Date(s) of treatment**
Ice	☐ Improved	☐ Worsened	☐ Unchanged	
Heat	☐ Improved	☐ Worsened	☐ Unchanged	
Rest	☐ Improved	☐ Worsened	☐ Unchanged	
NSAIDs	☐ Improved	☐ Worsened	☐ Unchanged	
Muscle Relaxers	☐ Improved	☐ Worsened	☐ Unchanged	
Chiropractor	☐ Improved	☐ Worsened	☐ Unchanged	
Physical Therapy	☐ Improved	☐ Worsened	☐ Unchanged	
Home Exercises	☐ Improved	☐ Worsened	☐ Unchanged	
Surgery	☐ Improved	☐ Worsened	☐ Unchanged	
Injections	☐ Improved	☐ Worsened	☐ Unchanged	
Bracing	☐ Improved	☐ Worsened	☐ Unchanged	

Other treatments/Comments: _____
_____
_____

Medical Questions

Mark all that currently apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep apnea ☐ Uses a CPAP ☐ Snores

Are you taking blood thinners? ☐ Yes ☐ No

Patient name: _____

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months:

☐ None for all

				None	Comments
1.	☐ Weight loss	☐ Loss of appetite	☐ Fatigue	☐	_____
2.	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐	_____
3.	☐ Hearing loss	☐ Hoarseness	☐ Trouble swallowing	☐	_____
4.	☐ Chest pain	☐ Palpitations		☐	_____
5.	☐ Chronic cough	☐ Pneumonia	☐ Shortness of breath	☐	_____
6.	☐ Heartburn	☐ Nausea/vomiting	☐ Blood in stool	☐	_____
7.	☐ Painful urination	☐ Blood in urine	☐ Kidney problems	☐	_____
8.	☐ Frequent rashes	☐ Skin ulcers	☐ Psoriasis	☐	_____
9.	☐ Frequent falls	☐ Loss of coordination	☐ Numbness		
	☐ Change in bowel	☐ Change in bladder	☐ Dizziness	☐	_____
10.	☐ Sleep disorder	☐ Depression/anxiety	☐ Drug/alcohol addiction	☐	_____
11.	☐ Fever	☐ Night sweats	☐ Heat/cold intolerance	☐	_____
12.	☐ Easy bleeding	☐ Easy bruising	☐ Anemia	☐	_____

Social History

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic partnership

Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled ☐ Student

If yes: Occupation: _____ Employer: _____

If no, what date did you last work? _____
mm/dd/yyyy

Please list any work restrictions, if any: _____

Medical History

Do you have a personal history of any of the following? ☐ None

☐ Aneurysm location: _____	☐ Emphysema	☐ Kidney disease
☐ Angina (chest pain)	☐ Epilepsy	☐ Kidney stones
☐ Arthritis type: _____	☐ Heart attack	☐ MRSA infection
☐ Asthma	☐ Hepatitis type: _____	☐ Pacemaker
☐ Bone/joint infection	☐ HIV/AIDS	☐ Phlebitis/blood clots
☐ Cancer type: _____	☐ High cholesterol	☐ Pulmonary embolism
☐ Chemotherapy/radiation	☐ Hypertension	☐ Reaction to anesthesia
☐ COPD	☐ Hyperthyroidism	☐ Seizures
☐ Congestive heart failure	☐ Hypothyroidism	☐ Stomach ulcers
☐ Diabetes type: ____Last A1C: ____	☐ Stroke/TIA	☐ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____ _____

Signature of patient/guardian Date