FORM HAND THERAPY

39180 Farwell Drive
Fremont, CA 94538
phone: 510.585.2535
fax: 510.474.1798
www.fremonthandtherapy.com

Patient Registration

Today's Date: ____/____/_____ Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Patient's Last Name: _____ First: _____ Middle Initial: ____

SS #: _____-____-_____ Date of Birth: ____/____/_____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Primary Language: _____ Race/Ethnicity: _____

Home Address: _____ Apt #: _____

City: _____ State: ____ Zip Code: _____ Email address: _____

OCCUPATION: _____ Employer: _____

Employer Address: _____

City: _____ State: ____ Zip Code: _____ Work Phone: _____-_____-_____

Emergency Contact: _____ Emergency Phone #: _____-_____-_____

How did you hear about us? ☐ Friend/Relative (Name: _____) ☐ Employer

☐ Ad (Location: _____) ☐ Web (Website: _____) ☐ Other: _____

PRIMARY INSURANCE: _____Subscriber to Ins: ☐ Self ☐ Spouse ☐ Parent ☐ Company

Last Name: _____ First Name: _____ Middle Initial: ____

Relationship to Patient: _____ SS #: _____-____-_____ D.O.B: ____/____/_____

Subscriber ID: _____ Group #: _____ Ins Phone #: _____-_____-_____

Ins Address: _____City: _____ State: ____ Zip Code: _____

SECONDARY INSURANCE: _____ Subscriber to Ins: ☐ Self ☐ Spouse ☐ Parent ☐ Company

Last Name: _____ First Name: _____ Middle Initial: ____

Relationship to Patient: _____ SS #: _____-____-_____ D.O.B: ____/____/_____

Subscriber ID: _____ Group #: _____ Ins Phone #: _____-_____-_____

Ins Address: _____City: _____ State: ____ Zip Code: _____

WORKERS COMPENSATION: Did you report the injury to your Employer? ☐ Y ☐ N Date of Injury: ____/____/_____

Time: _____☐ AM ☐ PM Claim #: _____ Where Injury Occurred: _____

Employer Contact Ph: _____-_____-_____ Do you have an attorney for your case? ☐ Yes ☐ No

Attorney Name: _____ Attorney Ph: _____-_____-_____

Claims Adjuster Name: _____ Claims Adjuster Ph: _____-_____-_____ Fax: _____-_____-_____

Ins Address: _____City: _____ State: ____ Zip Code: _____

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying FORM Hand, Wrist & Elbow Institute of **any changes** made to my contact information and/or insurance. DATE: ____ / ____ / ____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY: _____

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FINANCIAL POLICY

PATIENTS WITH INSURANCE:
Although we bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. _____initial here
If payment has not been received within sixty (60) days of billing your health pan/medical group, we may contact you for assistance. If your health plan/medical group denies coverage for any reason, you will be responsible for that payment in full within thirty (30) days of receipt of your billing statement.

CLAIM FILING:
As a convenience to you, our staff will file a claim on your behalf provided we have your current insurance policy information available. However, it is impossible for our staff to determine your coverage and payment levels, since each insurance company offers many options as part of their health care coverage package. Our staff cannot guarantee that your insurance carrier will pay all or even part of your claim. Your insurance policy is a contract between you and your insurance carrier. We file insurance claims as a courtesy for our patients. While we attempt to assist our patients with claims, any disputes with your insurer are not the responsibility of our practice.

Ultimately, the patient is responsible for their charges. Patients should resolve disputed coverage issues directly with their insurer or employer. It is the patient's responsibility to know the details of their insurance contract and our office is a network provider for their particular plan. _____initial here

BALANCES:
When your insurance company processes your claim they will provide you with an Explanation of Benefits (EOB). This EOB will explain what the insurance company has agreed to pay. Most insurance companies agree to pay only a percentage of the charges with the remaining balance being the responsibility of the patient. The EOB may use the term "Usual, Customary and Reasonable" (UCR). Insurance companies develop UCRs independently of one another. Basil R. Besh, M.D. Inc. maintains only one fee schedule and it is developed independently of the insurance company UCRs. Therefore, because of policy deductibles, co-payments, non-covered services and UCRs, you may have a balance due after insurance pays. _____initial here

UPDATES TO INSURANCE:
It is the patient's responsibility to ensure that the insurance information provided at the time of the visit is current and accurate. If there are changes to the insurance, patient should advise Basil R. Besh, M.D. Inc. at the time that patient is scheduling his/her appointment. _____initial here

CO-PAY, CO-INSURANCE AND DEDUCTIBLES:
It is the patient's responsibility to know their co-pay responsibilities, coinsurance and deductibles – and that these amounts are due at the time of service. Some insurance plans require that patients pay a predetermined percentage (e.g. 20%) of the allowed charge amount. If amount can be determined at time of service, amount will be collected.

AUTHORIZATION FOR TREATMENT:
Some insurance plans require you to receive a prior authorization for services by a specialist. Please review your policy to see if there is such a requirement and obtain this authorization prior to your visit with our clinic. While we may attempt to request authorization on your behalf, unfortunately some of the insurance companies do not have rapid response times. This may result in a delay in treatment. If the patient chooses to pursue treatments without authorization, the patient is ultimately responsible for the bill. _____initial here

OUT OF NETWORK:
Patients being seen as Out of Network may be required to pay a payment at the time services are rendered. As a courtesy, we will bill your insurance company.

DUAL COVERAGE:
Basil R. Besh, M.D. Inc. abides by the California State Insurance Laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary, and tertiary health plans. Dual coverage does not necessarily ensure that you will not have a co-pay for your office visit. If a co-pay is not collected at the time of your visit and subsequently your insurance plan states that a co-pay is due, you are responsible for paying that copay amount thirty (30) days from the date of receiving the billing statement. _____initial here

PATIENTS WITHOUT INSURANCE:
Our fees cannot always be determined in advance, since they depend on actual services provided. If you would like an estimated total amount before being seen, please ask our team. Please note that this is only an estimated amount and the actual charge totals may vary from this estimate. Payment for all services is due at the time of service. We do offer payment plans and custom financial arrangements

NO-SHOW POLICY:
The office requires twenty-four (24) hour notice of cancellation for scheduled appointments. In the event that we are not notified twenty-four (24) hours prior to your appointment, you may be charged a $75.00 fee for a missed doctor's appointment and $45 for a missed therapy appointment. For worker's compensation patients, adjustor will be notified for missed appointments. _____initial here

DELINQUENT ACCOUNTS:
Accounts not paid within sixty (60) days of the date of service may be turned over to a collection agency.

RETURNED CHECKS: There will be a $25.00 service fee for returned checks.

FEE FOR COPYING MEDICAL RECORDS:
There is a copying fee of $15.00 for medical records provided to a patient, insurance company, attorney, etc. However, there is no charge to transfer records to another provider upon request.

OTHER FEES:
There is a nominal charge of $15.00 for each form/report (i.e. DMV forms, school/sport physicals, etc…) that requires completion by the physician. However, this fee is waived if there is a separate scheduled appointment for this request. There is a $15.00 fee for any request for letters written (i.e. Health verification letters to insurances and employers, special circumstance letters, etc…) on your behalf as a patient.

METHODS OF PAYMENT ACCEPTED:
For your convenience, we accept cash, Mastercard, AMEX, Visa, debit cards, and personal checks.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:
I authorize the release of any medical information, which may have a bearing on the determination, and/or payment of my claim. I request that payment is made directly to Basil R. Besh, M.D. Inc. and I acknowledge that I am responsible for payment if this assignment is not honored. I understand that I am responsible for all co-payment, coinsurance, and deductible that I may have with my insurance. I further understand that I have been provided a service and it is my responsibility to know my own insurance coverage and be aware of services that may or may not be covered. I have read and understand the above policies, and I agree to comply with them. I attest that all information is true and accurate to the best of my knowledge.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY: _____

DATE:_____/____/_____

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Our Commitment to Quality Medical Care

Fremont Orthopaedic and Rehabilitative Medicine are committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice. We also understand that as a patient, you may at times have concerns or complaints about our services.

We encourage you to communicate your concerns to us or our staff. Please tell us if you have a complaint or a complement – *we value your feedback*. Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. **We appreciate being part of your health care team and greatly value your feedback.**

If you would prefer that your comment be anonymous, please find a comment box in our waiting room. If we are not able to answer your concern or complaint to your satisfaction, please contact the **Alameda-Contra Costa Medical Association**. If you have a complaint and we cannot resolve it together, we can refer you to an impartial dispute resolution committee of our local medical association. As members of the medical association, we have made a commitment to have any complaints you bring against us reviewed by a committee of peers. **Contact ACCMA at 510-654-5383.**

If the above suggestions are not satisfactory, or for any reason, you may contact the **Medical Board of California**. We offer this NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (**1-800-633-2322 or www.mbc.ca.gov**).

I have read and understand the options available to me in regards to my medical care.
I understand that medical doctors are licensed and regulated by the Medical Board of California.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY: _____

DATE: ____/____/_____

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Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that Basil R. Besh, M.D. Inc. has given you a copy of its PRIVACY NOTICE, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after emergency.

Please check all that are true:

___ I have received the PRIVACY NOTICE from Basil R. Besh, M.D. Inc.

___ Basil R. Besh, M.D. Inc. has given me the chance to discuss my concerns and questions about the privacy of my health information.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY: _____

RELATIONSHIP TO THE PATIENT (if signing for someone else): _____

DATE: ____/____/_____

*Please complete and sign the Disclosure Form if you wish anyone else to have access to your records, or if you wish to allow another person to call or pick up items on your behalf. If this form is not completed, we will not disclose any information to anyone (example: wife, children, lawyer, etc.)

OFFICE USE ONLY

Patient Name: _____ Date of Visit: ____ / ____ / _____

Does Patient have a copy of the PRIVACY NOTICE? Y / N

If the patient was unable to sign an acknowledgement form, describe the efforts in trying to obtain the patient's signature:

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Notice of Privacy Practices

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

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:
Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:
Unless otherwise required by law that your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect, and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, and revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:
Basil R. Besh, M.D. Inc. is required to maintain the privacy of your health information. In addition, we are required to provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. If we maintain a Web site that provides information about our customer services or benefits, we will post our new notice on that Web site. We will not use or disclose your health information without your authorization, except as described in this notice.

HOW WE WIL USE YOUR HEALTH INFORMATION:

We will keep your health information confidential, using it only for the following purposes:

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the Emergency Department and Radiology, or certain laboratory tests. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. TO protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to care.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Notice of Privacy Practices availability: This notice will be prominently posted in the office where registration occurs. Patients will be provided a hard copy and the notice will be maintained on our Web site for downloading

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

YOUR PRIVACY RIGHTS AS OUR PATIENT:

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $15.00. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.) Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS:

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Basil R. Besh, M.D. Inc.
Privacy Officer: Amirra Besh, Administrator
Telephone: 510.857.1000
Fax: 510.857.1001
Address: 39180 Farwell Drive, Fremont, CA 94538

FORM
HAND THERAPY

NARCOTICS POLICY

Your health and safety is the single most important thing to us. To that end, we want to take this opportunity to make you aware of our narcotic pain medication policy.

Narcotic pain medications are opium derivatives and include, but are not limited to, hydrocodone (Vicodin, Norco), oxycodone (Percocet), codeine, and other morphine derivatives. All of these medications have dangerous side effects as well as addictive potential. Therefore, it is important that we have a policy for use of these dangerous medications here in our office. While your comfort is important to us, it can never supersede you safety and general welfare.

1. We never use narcotics for chronic pain conditions, which include, but are not limited to, arthritis, tendonitis, etc.
2. A single prescription shall be given for an acute event such as surgery, injuries such as fractures, or lacerations.
3. Prescriptions given for surgery during the preoperative visit should not be used prior to the day of surgery and should be used as sparingly as possible during the postoperative period.
4. Narcotic medications are **NEVER** to be used as a sleep aid, as there are safer alternatives to help manage temporary insomnia.
5. No refills shall be given on the initial prescription unless there is an additional acute event such as a new injury or a new surgery.

We hope you understand that we do this because we care about your safety and your health above all else. We want to be clear that this policy in no way should be interpreted as minimizing the importance of your pain, but we would never want the treatment to be worse than the disease.

If you have any questions, please don't hesitate to ask.

Warmest regards,

Basil R. Besh, M.D.

BRB/hf

I, _____ (Patient Name), acknowledge that I have read the above narcotics policy and was provided the opportunity to ask and receive answers for all of my questions on this policy.

_____ _____

Patient Signature Date

39180 Farwell Drive Suite 211 | Fremont, CA 94538 p: 510.857.1000 Fax: 510.857.1001

FORM HAND THERAPY

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www.fremonthandtherapy.com

Authorization for Disclosure of Health Information

PATIENT INFORMATION:

Name: _____ Date of Birth: ____ / ____ / _____

Street Address: _____

City: _____ State: _____ ZIP: _____

AUTHORIZES:

Health Care Provider: _____

St. Address: _____

City: _____ State: ____ Zip Code: _____

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Health Care Provider: _____

St. Address: _____

City: _____ State: ____ Zip Code: _____

INFORMATION TO BE RELEASED:

___ Medical History, Examination, Reports ___ Surgical Reports ___ Immunizations ___ Treatment or Tests

___ Hospital Records Including Reports ___ X-ray Reports ___ Allergy Records ___ Laboratory Reports

___ Prescription ___ Consultations ___ Entire Record ___ Other (Specify): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___ Insurance Eligiblity/Benefits ___ Legal Investigation or Action ___ Further Medical Care ___ Personal

___ Changing Physicians ___ Other (Specify): _____

MY RIGHTS: I understand that I am not required to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). However, I must sign an authorization:

To take part in a research study OR To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by The physicians of FORM, based upon this authorization. I may not be able to revoke this authorization If its purpose was to obtain insurance. Two ways to revoke this authorization are:

Fill out a revocation form (available at the Front Desk) OR Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT (if signing for someone else): _____

DATE: ____/____/____