PATIENT REGISTRATION FORMS

Patient's Name: First___________________________ **Middle Initial**_____ **Last**__________________________________ **DOB:**____/____/______

Address: ____**City:**________________________ **State:** ______ **Zip:**________________

Primary Phone: _______-_______-___________ **Secondary Phone:** _______- ________-____________
(Circle: home or cell) (Circle: home or cell)

Email: ____(for patient portal purposes only)

Marital Status (please circle): S M W D Other **Sex (please circle):** Male Female **SSN:** ________-______-___________

Referring Doctor:
Name, Address and Phone:____

Primary Care Doctor:
Name, Address and Phone:____

Language: ____________________________________ **Ethnicity:** (please circle) Hispanic or Latino Non Hispanic or Latino Other

Race: (please circle) Alaskan Native/American Indian, Asian, Black/African American, Native Hawaiian/Other Pacific Islander, White, Declined to Answer

Employer:____ **Address:**___________________________________**Phone:**________________________

Emergency Contact: ____**Phone:**______-______-__________ **Relation:**______________________
(Different from above) (Circle: cell or home)

GUARANTOR INFORMATION: COMPLETE THIS SECTION IF PATIENT IS A MINOR

Patient's Relationship to Guarantor: ___________________**Name:**____

Address:____**City:**_________________________**State:**_______ **Zip:**______________

Primary Phone: _______-_______-__________ **Secondary Phone:** _______- ________-____________
(Circle: home or cell) (Circle: home or cell)

SSN: __________-________-______________ **DOB:**_____/_____/________ **Sex (please circle):** Male Female

Employer Name and Address:____ **Phone:**________________________

INSURANCE INFORMATION
(We must obtain copies of ALL insurance cards if filing with personal insurance)

(Please Circle) **Is this personal health insurance? Work Comp? Liability? Date of Injury/Symptoms:**_____/_____/_______

PRIMARY INSURANCE :____**ID/Policy/Number:**______________________________

Subscriber Name:____ **DOB:**____/_____/______ **Patient Relation to Insured:** _________________

Address:____**City:**_________________________**State:**_______ **Zip:**______________

Primary Phone: _______-_______-__________ **Secondary Phone:** _______- ________-__________ **SSN:**_______-_____-__________ **Sex: M or F**
(Circle: home or cell) (Circle: home or cell)

Subscriber Employer Name and Address:
____**Phone:**_______-________-___________

Contact or Adjuster's Name and Phone: ____

SECONDARY INSURANCE:____**ID/Policy/Number:**_________________________________

Subscriber Name:____ **DOB:**____/_____/______ **Patient Relation to Insured:** _________________

Address:____**City:**_________________________**State:**_______ **Zip:**______________

Primary Phone: _______-_______-__________ **Secondary Phone:** _______- ________-__________ **SSN:**_______-_____-__________ **Sex: M or F**
(Circle: home or cell) (Circle: home or cell)

Subscriber Employer Name and Address:
____**Phone:**_______-________-_________

We need your E-mail address…….

As we transition to electronic medical records, you will have the availability to access a summary of your visit via the internet. In order to make this happen we need your e-mail address. Once we are set up, you will receive a secure link sent to your email address that you can use. No protected health insurance information will be sent to your e-mail account. We will not sell or share your email address with any outside practices.

Please fill out below, print the patient name and preferred e-mail address (sorry, our system only allows one email address per account) and hand it to any of the front desk personnel. If you are declining to give us an email or if you do not have an email, please mark the appropriate box, sign the form and return it to the front desk. If you have any questions on providing the email address, the receptionists will be glad to answer them.

E-mail Address: ____

□ I do not have an email address
□ I decline to provide my email address

Signature: ____

Consent to Obtain Electronic Medication History, Telephone Calls and Email Usage

I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable informaton for my healthcare provider. I hereby authorize Kleinert Kutz to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

If at any time I provide a telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the provider to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

If at any time I provide my email address at which I may be contacted, unless I notify the provider to the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at that email address from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

____

Pharmacy Name   Pharmacy Phone #

____

Pharmacy Location

X____

Signature   **Date**

KLEINERT KUTZ
Hand Care Center

CHRISTINE M. KLEINERT INSTITUTE
For Hand And Microsurgery

HEALTH INFORMATION SHEET

Patient Name:____ Date:________________________

Age:________ Height:_________Weight:________ Family/Primary Care Physician: ______________________________

Which side is affected? Right:_______ Left:________ Both:________

Date of injury or onset symptoms? ____

Describe what happened and/or the type of problems you are having?____

____

____

Does your health/injury prevent you from performing needed daily activities and/or activities you enjoy? Yes_____ No_____

If yes, please explain: ____

If injured, where did your injury take place? _____________________________City/State: _______________________

Did this happen at work or do you feel it's directly related to your job duties? ____________________________________

Have you filed a Worker's Comp claim? Yes_____ No_____ Are you still working for same company? Yes_____ No______

Have you had previous injuries or problems to affected part? Yes_____ No______ If yes, what type? __________________

____

Have you had previous treatment for the above symptoms or injury? Yes______ No______ If yes, what type? ____________

____

GENERAL SOCIAL HISTORY

Smoking: □ Current everyday smoker □ Current occasional smoker □ Former smoker □ Never smoked

If smoker or former smoker: Number of years?_______ Number of packs a day?_________

I drink alcohol: □ Daily □ Monthly □ Never □ Rarely □ Weekly

Are you currently disabled? Yes_____ No_____ Have you ever filed for disability? Yes_____ No_____

Are you right-handed or left-handed? R________ L________

Do you have a living will? Yes_____ No_____

Marital Status: Married □ Divorced □ Single □ Widowed □ Do you live alone? Yes_____ No_____

Are you currently working? Yes____ No_____ If so, how long have you been at your place of employment?___________

Occupation: (Please describe briefly what your job requires.) ____

____

Do you have a durable power of attorney? Yes_____ No_____

If yes, who?____ Phone: _(_______)_________________________

Do you have a legal guardian? Yes_____ No_____

If yes, who?____Phone:_(_______)_________________________

Recreational Drug Use: □ Yes □ No □ Former Use

FAMILY MEDICAL HISTORY

Has anyone in your **family** been treated for the following? If YES, then please put **family relation AND** specify if **maternal** (mother's side) or **paternal** (father's side) if it applies to the relation.

CONDITION	YES	NO	RELATION	CONDITION	YES	NO	RELATION
1) Arthrits/Rheumatoid				13) Hepatitis			
2) Bleeding disorder				14) High Blood pressure			
3) Bone disease				15) Kidney or bladder problems			
4) Cancer				16) Liver Problems			
5) Chemical Dependency				17) Lung Problems (asthma, sleep apnea)			
6) Chronic Pain				18) Mental illness			
7) Depression				19) Skin Conditions/Psoriasis			
8) Diabetes				20) Stomach problems			
9) Disabled				21) Stroke			
10) Epilepsy or seizures				22) Ulcers			
11) Gout				23) Other			
12) Heart Disease							

PATIENT MEDICAL HISTORY

Are you (**patient**) currently or have you previously received treatment for the following?

CONDITION	YES	NO		CONDITION	YES	NO
1) Anxiety				14) High Blood pressure		
2) Arthrits				15) Kidney or bladder problems		
3) Asthma				16) Liver Problems		
4) Bleeding disorder				17) Lung Problems		
5) Cancer				18) MRSA		
6) Chemical Dependency				19) Rheumatoid Arthritis		
7) Cholesterol (high)				20) Skin Conditions/Psoriasis		
8) Chronic Pain				21) Sleep Apnea		
9) Diabetes				22) Stomach problems		
10) Epilepsy or seizures				23) Stroke		
11) Gout				24) Ulcers		
12) Heart Disease				25) VRE		
13) Hepatitis				26) Other		

SURGERIES

Have you ever had surgery or been hospitalized? Yes______ No______ If yes, please fill in the below:

OPERATION or REASON FOR ADMISSION	ANESTHESIA (local or general)	DATE	ANY PROBLEMS?

Have you or anyone in your family had problems or reactions to anesthesia? ____

List all your CURRENT MEDICATIONS:____

____

____

____

What is your prefered pharmacy? _______________________________________

Are you receiving narcotic medication from any other physician? Yes_____ No_____

If yes, Physician name:____Medication:_______________________

Are you allergic to Latex? Yes or No

ALLERGIES (food & drug)**: Yes or No**	Reaction:

REVIEW OF SYSTEMS

Please check (x) the following symptoms that apply to you.

1. Cardiovascular	□ None	□ Painful breathing □ Palpitation □ Chest Pain □ Swelling of Legs □ Difficulty breathing on exertion □ Other ____
2. Constitutional	□ None	□ Fatigue □ Weight Gain □ Weight Loss □ Fever □ Other ____
3. Ear, Nose & Throat	□ None	□ Sore Throat □ Mouth Sores □ Sinusitis □ Hearing Loss □ Other ____
4. Endocrine	□ None	□ Diabetes □ Heat/Cold Intolerance □ Hypothyroid □ Hyperthyroid □ Hair Loss □ Hot Flashes □ Other ____
5. Gastrointestinal	□ None	□ Diarrhea □ Constipation □ Bloody Stool □ Pain □ Indigestion □ Nausea/Vomiting □ Other ____
6. Head & Eyes	□ None	□ Headache □ Vision Change □ Glasses/Contacts □ Other ____
7. Hematologic/ Lymphatic	□ None	□ Bruises □ Enlarged Lymph Nodes (Glands) □ Bleeding □ Other ____
8. Muscoskeletal	□ None	□ Muscle Weakness □ Muscle or Joint Pain □ Other ____
9. Neurologic	□ None	□ Severe Memory Problems □ Seizures □ Fainting □ Numbness □ Trouble Walking □ Other ____
10. Psychiatric	□ None	□ Depression □ Crying □ Severe Anxiety □ Other ____
11. Respiratory	□ None	□ Wheezing □ Cough □ Shortness of Breath □Spitting up Blood □ Other ____
12. Skin	□ None	□ Rash □ Dry Skin □ Sores □ Moles □ Other ____
13. Urinary	□ None	□ Blood in Urine □ Incomplete Emptying □ Painful Urination □ Frequency □ Urgency □ Incontinence □ Other ____

Consent for Treatment in the Office at Kleinert Kutz

I hereby consent to the rendering of care, including diagnostic procedure and treatment, as the attending physician or physicians under their supervision consider appropriate and necessary. I understand that I will be informed of the risks of any proposed procedures and treatment and I should decline treatment unless such risks are explained to my satisfaction. I also consent to the taking of any photographs, moving pictures, television and/or audiovisual aids in the course of medical treatment for the purpose of advancing medical knowledge through anonymous use in medical teaching, lecturing and/or anonymous publication in medical texts, journals or other medical publications.

Authorization to Release Information

I hereby authorize the release of information regarding my condition and treatment to any referring or consulting health care personnel or any health, liability or worker's compensation insurance carrier, agent, attorney or other representative purporting to act of my behalf, and any facility at which I may be treated, examined or evaluated. If I am here for an Independent Medical Exam or second opinion, I further authorize the release of information regarding my condition and treatment to the person or entity requesting such examination or opinion and to any agent, attorney or other representative of such person or entity.

Ancillary Services

I understand that I may be prescribed physical or occupational therapy, corrective appliances, devices and/or braces. I also understand that it is my responsibility to timely obtain authorization from my insurance carrier when required by my plan and be responsible for the payment of any such prescribed services. Kleinert, Kutz and Associates will assume no responsibility for the quality of the delivered product or service unless it has been acquired from the Christine M. Kleinert, Hand Therapy Center or Orthotic Care Center and the prescribed treatment protocol is followed.

Legal Process

In the event I, on behalf of myself or my child or ward, pursue personally, or through the efforts of an attorney, a claim against any party for personal injuries being treated by Kleinert, Kutz and Associates, I will be responsible for notifying the payer and/or responsible person, that out of the proceeds of any settlement or judgment, Kleinert, Kutz and Associates is to be paid for services in full. I also will notify Kleinert, Kutz and Associates of my pursuit of such claim.

In the event that I obtain any attorney, I agree to notify such attorney of this agreement which I have hereby made with Kleinert, Kutz and Associates and further authorized Kleinert, Kutz and Associates to provide my attorney with a copy of this agreement and any other information requested by this attorney. I understand that by receiving services from Kleinert, Kutz and Associates and/or its entities, I agree that I am solely responsible for payment of all medical bills upon receipt of said services. Kleinert, Kutz and Associates make no agreement not to proceed with normal collection activity on my unpaid balances.

Assignment of Insurance Benefits

I hereby authorize my current insurance carrier to pay Kleinert, Kutz and Associates out of any benefits due on this claim. I understand that I am financially responsible to the doctor for any charges not covered under this assignment (a copy is as valid as the original).

Payment for Services

I understand that Kleinert, Kutz and Associates **may** or **may not** be a participating provider with my insurance carrier and it's **my responsibility** to verify this status with my insurance. I understand as the patient, Kleinert, Kutz and Associates will file all insurance claims as a courtesy. I also understand that my insurance is a contract between my employer, the insurance company and me and that Kleinert, Kutz and Associates is not a party to that contract. I understand as the patient that I am responsible for all charges from the dates the service is rendered. I agree that any additional requests for information from my insurance company regarding coverage, coordination of benefits, dates of injury, or any related questions will be answered by me in a timely manner, or the balance due will become my responsibility. All co-payments, deductibles and past balances are due at the time of service. The only exception is if I have a verified worker's compensation claim.

If Kleinert, Kutz and Associates are not a participating provider with my insurance, I will pay for services on the date they are rendered until a claim is established with my insurance company. This may include office visits, x-rays, orthotic devices, therapy or other services. In the event this matter is referred to Collections, I agree to pay all court costs, collection fees and attorney fees associated with the collections of this account.

****Kleinert Kutz has the right to charge my account $25.00 if I fail to give a 24 hour cancellation notice.****

This is a Legally Binding Document – Read Before Signing
I understand and agree that all of the provisions of this **Consent to Treatment in Office** shall remain in full force and effect until revoked by me **in writing**.

PRINT Patient's Name:____If Patient is a minor; they are ____ years of age

Subscriber's Name:____Date:______________________________________

Signature:_X____(Office Use Only –Witness):_______________________________

(Signature of Patient or Legal Guardian)

CHRISTINE M. KLEINERT INSTITUTE
For Hand And Microsurgery

Consent for Treatment in the Christine M. Kleinert Institute

I hereby consent to the rendering of care as considered appropriate and necessary by the attending physician or physicians under his/her supervision (Surgical Assistants).
I consent to the treatment by the Hand Therapy Center and/or Orthotic Care Center (physical or occupational therapy, corrective appliances, devices and/or braces) prescribed by a physician or requested by another source within legal guidelines.
I also consent to the taking of photographs, moving pictures, television and/or audiovisual aids in the course of medical treatment for the purpose of advancing medical knowledge through anonymous use in medical teaching, medical lecturing and/or anonymous publication in medical texts, medical journal or other medical publications.

Authorization to Release Information

I hereby authorize the release of information regarding my condition and treatment to any referring or consulting health care personnel or any health, liability or worker's compensation insurance carrier, agent, attorney or other representative purporting to act on my behalf, and any facility at which I may be treated, examined or evaluated. If I am here for an Independent Medical Examination or second opinion, I further authorize the release of information regarding my condition and treatment to the person or entity requesting such examination or opinion and to any agent, attorney, or other representative of such person or entity.

Legal Process

In the event I, on behalf of myself or my child or ward, pursue personally, or through the efforts of an attorney, a claim against any party for personal injuries being treated by Christine M. Kleinert clinical staff, I will be responsible for notifying the payer and/or responsible person, that out of the proceeds of any settlement or judgment, the Institute is to be paid for services in full. I also will notify the Institute of my pursuit of such claim.
In the event that I obtain an attorney, I agree to notify such attorney of this agreement which I have hereby made with the Institute and further authorize the Institute to provide my attorney with a copy of this agreement and any other information requested by said attorney. I understand that by receiving services from Christine M. Kleinert Institute and/or its entities, I agree that I am solely responsible for payment of all medical bills upon receipt of said services. Christine M. Kleinert makes no agreement not to proceed with normal collection activity on my unpaid balances.

Assignment of Insurance Benefits

I do hereby authorize current insurance carrier to pay the Christine M. Kleinert Institute out of any benefits due on this claim. I understand that I am financially responsible to the Institute for any charges not covered under this assignment (**a copy is as valid as the original**). I will timely obtain any authorization from my insurance carrier when required by my plan.

Payment for Services

Services normally covered by your insurance policy will be billed to your insurance company. You will be responsible for all charges not paid by your insurance company and for follow up on claims needing attention (depending on your individual policy contract). I agree that any additional requests for information from my insurance company regarding coverage, coordination of benefits, dates of injury, or any related questions will be answered by me in a timely manner, or the balance due will become my responsibility. All co-payments, deductibles and past balances are due at the time of service. The only exception is if I have a verified worker's compensation claim.

This is Legally Binding Document – Read Before Signing

PRINT Patient's Name:___________________________________If patient is a minor; they are ____ years of age

Subscriber's Name:____Date:__________________________________

Signature:_X____(Office Use Only –Witness):______________________________
(Signature of Patient or Legal Guardian)

CHRISTINE M. KLEINERT INSTITUTE
For Hand And Microsurgery

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

If you would like to have a copy of the Notice of Privacy Practices for your own records, please request one at the registration desk.

SIGNED: _X____ DATE: _________________

If not signed by the patient, please indicate relationship to patient (e.g., parent, legal custodian)

Relationship: ______________________________

Witnessed by: ______________________________

IF THE PATIENT OR REPRESENTATIVE REFUSES OR IS UNABLE TO SIGN, INDICATE YOUR ATTEMPT TO OBTAIN A SIGNATURE BELOW.

[ ] Patient refused to sign this acknowledgment

[ ] Patient is unable to sign due to injury

DATE: ________________________ TIME: ____________________

EMPLOYEE: __________________________________

WITNESS: ___________________________________

This acknowledgment applies to the following business entities:

Kleinert, Kutz and Associates
Christine M. Kleinert Institute for Hand and Microsurgery, Inc.
Kleinert Kutz Surgery Center in affiliation with Floyd Memorial Hospital