PATIENT REGISTRATION FORMS

KLEINERT KUTZ Hand Care Center

CHRISTINE M. KLEINERT INSTITUTE For Hand And Microsurgery

Patient's Name: First_____ **Middle Initial**_____ **Last**_____ **DOB:**____/____/_____

Mailing Address: _____**City:**_____ **State:** _____ **Zip:**_____

Primary Phone: _____-_____-_____ **Secondary Phone:** _____- _____-_____

Email: _____**(for appt reminders & 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: ☐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:**_____
dfadsfasdf
Address:_____**City:**_____**State:**_____ **Zip:**_____

Primary Phone: _____-_____-_____ **Secondary Phone:** _____- _____-_____

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)

(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** ☐**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** ☐**F**

Subscriber Employer Name and Address:
_____**Phone:**_____-_____-_____

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 employed with 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:_____

_____

_____

_____

Are you receiving narcotic medication from any other physician? Yes☐ No☐

If yes, Physician name:_____Medication:_____

Are you allergic to Latex? ☐Yes ☐No

ALLERGIES (food & drug): ☐Yes ☐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)

KLEINERT KUTZ
Hand Care Center

CHRISTINE M. KLEINERT INSTITUTE
For Hand And Microsurgery

HIPAA CONSENT FORM

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.

I have been given the opportunity to review 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 permit Kleinert Kutz to disclose to my Personal Health Information (PHI) to the following:

Please check all that apply:

Myself Only☐ **Spouse☐** **Parents☐** **Sibling(s)☐**

Adult Children☐ **Personal Representative☐** **Employer☐**

Please print name(s) of above: _____

_____

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.

SIGNED: _X_____DATE: _____

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

Relationship: _____

Witnessed by: _____

OFFICE USE ONLY:

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, LLC