HAND & UPPER EXTREMITY CENTER, PA

OLAYINKA OGUNRO, M.D., F.A.C.S
CHARITY OGUNRO, M.D.

PATIENT INFORMATION SHEET

THIS FORM MUST BE FILLED OUT WITH ALL APPLICABLE INFORMATION
NOTE: PATIENT IS RESPONSIBLE FOR ALL BILLS

PLEASE PRINT

Date: _____

Patient's Name: _____ SS #: _____

Single: _____ Married: _____ Separated: _____ Widow: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Date of Birth: _____ Age: _____ Sex: _____ Hm. Phone: _____

Weight: _____ Height: _____ Pharmacy Name & No: _____

Cell #: _____ E-Mail Address: _____

Race: White, Hispanic, Asian, African-American, Other _____ Ethnicity: _____

Patient's Responsible Party's Employer: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Position: _____ Work Phone: _____

Spouse Name: _____ Employer: _____

If child, parent's name: _____ SS #: _____

Nearest Relative: _____ Phone #: _____

Insured's Name: _____ SS #: _____

Insured's D.O.B.: _____

Insurance Co: _____ Phone #: _____

Group #: _____ Cert. or Policy #: _____

Drivers License #: _____ Referred By: _____

On the job injury: Yes: _____ No: _____

Claim Number: _____ Date of Injury: _____

Chief Complaint (Reason for visit): _____

Present illness, include dates and previous treatment:_____

Family History:_____

Past Medical History (diabetes, hypertension, HIV, heart problems, gastric ulcers, etc.): _____

Past Surgeries: _____

Review of systems: (Please circle all that apply)
General: chills, fever, fatigue, night sweats and weight loss
HEENT: hearing problems, ear/nose/throat pain, congestion, runny nose, nose bleeds, hoarseness and dental problems
Cardiovascular: chest pain, palpitations, increased heart rate, orthopnea, and edema.
Respiratory: cough, dyspnea, and coughing up blood
Gastrointestinal: abdominal pain, heartburn, constipation, diarrhea and stool changes
Urinary: urgency, frequent urination, painful urination, blood in the urine, waking up at night to urinate, incontinence, stones, infection
Vascular: leg edema, leg cramping, varicose veins, thromboses/emboli
Musculoskeletal: muscle weakness, pain, joint stiffness, instability, redness, swelling, gout, except for areas of symptoms.
Neurologic: loss of sensation, numbness, tingling, tremors, weakness, paralysis, fainting, blackouts, seizures
Endocrine: heat/cold intolerance, excessive sweating, polyuria, polyphagia, excessive thirst

Personal History:

Use of drugs: Yes:_____ No:_____ How much:_____

Do you smoke: Yes:_____ No:_____ How much:_____

Do you drink alcohol: Yes:_____ No:_____ How much:_____

Current Medications You Are Taking: _____

Are you taking: Diet Pills, Vitamins or Herbs:_____

Allergies to medications:_____

Are you Right Handed:_____ or Left Handed:_____

Type of work you do? _____

Describe in detail your job duties: Example…Pushing, Pulling, Keying, Bending, Lifting (How many lbs?) and Typing.

I hereby authorize my insurance benefits to be paid to the physician and I do realize I am financially responsible for non-covered services. I also authorize the physician to release any medical information and records required in the processing of claims.

_____ _____

Patient's Signature Date

Hand & Upper Extremity Center

Standard Authorization of Use and Disclosure of Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Purpose of Disclosure
Information listed above will be disclosed for the following purposes:

_____

_____

_____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

_____
Name of person/organization

_____
Name of person/organization

_____
Name of person/organization

Person to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____
Name of person/organization

_____
Name of person/organization

_____
Name of person/organization

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **Hand & Upper Extremity Center**. You should contact the **Office Manager** to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information one **Hand & Upper Extremity Center** discloses it to another party.

Rights of the Individual

- ◊ You may inspect or copy information used under this authorization.
- ◊ You may refuse to sign this authorization.

Effect of Refusing Authorization

If you refuse to sign this authorization, **Hand & Upper Extremity Center** will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

_____

Treatment conditioned on authorization

_____

Treatment conditioned on authorization

Signature

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative

Hand & Upper Extremity Center
Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Hand & Upper Extremity Center**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example. We are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- ◊ The right to request restrictions on the use and disclosure of your protected health information
- ◊ The right to receive confidential communications concerning your medical condition and treatment
- ◊ The right to inspect and copy your protected health information
- ◊ The right to amend or submit corrections to your protected health information

- ◊ The right to receive an accounting of how and to whom your protected health information has been disclosed
- ◊ The right to receive a printed copy of this notice

Hand & Upper Extremity Center Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices."

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Front office staff** or **Office Manager.** Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
Hand & Upper Extremity Center
3450 W. Wheatland Rd, POB II Suite 430
Dallas, TX 75237

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is:

Office Manager
Hand & Upper Extremity Center
3450 W. Wheatland Rd, POB II Suite 430
Dallas, TX 75237
972-296-3875

Effective Date

This notice is effective on or after month _____ day _____ year_____.

Hand & Upper Extremity Center

Acknowledgement of Notice of Privacy Practices

Hand & Upper Extremity Center reserves the right to modify the privacy practices out-lined in this notice.

Signature
I have received a copy of the "Notice of Privacy Practices" for **Hand & Upper Extremity Center**.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient