Aimee L. Schimizzi, MD
Patient Intake Form

Last Name: _____ First Name: _____

DOB: ___/___/____ Legal Sex: Male Female SSN: _____

Cell Phone: _____ Home Phone: _____ Preferred: Cell Home

Home Address:
_____

City: _____ State: _____ Zip Code:_____

Email: _____

Occupation: _____

Employer: _____ Work Phone: (____)____-_____

Work Address:
_____

City: _____ State: _____ Zip Code:_____

Primary Care Provider (PCP): _____PCP Phone:_____

Referring Provider: _____ Referring Phone: _____

How did you hear of us? _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Primary Insurance Co_____ Insurance ID# _____ Group # _____

Name of Insured: _____ DOB: _____

Relationship to Insured: _____ Insured's Social Security # _____

Secondary Insurance: _____ Insurance ID# _____ Group # _____

Name of Insured: _____ DOB: _____

Relationship to Insured: _____ Insured's Social Security # _____

Legal Guardian/ Power of Attorney: _____

Relationship: _____ Phone # _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients:

Ethnicity:

Decline Response Hispanic or Latino Not Hispanic or Latino

Race:

Decline Response Black or African American American-Indian or Alaska Native

Asian Native Hawaiian or Pacific Islander White Other

Preferred Language: _____

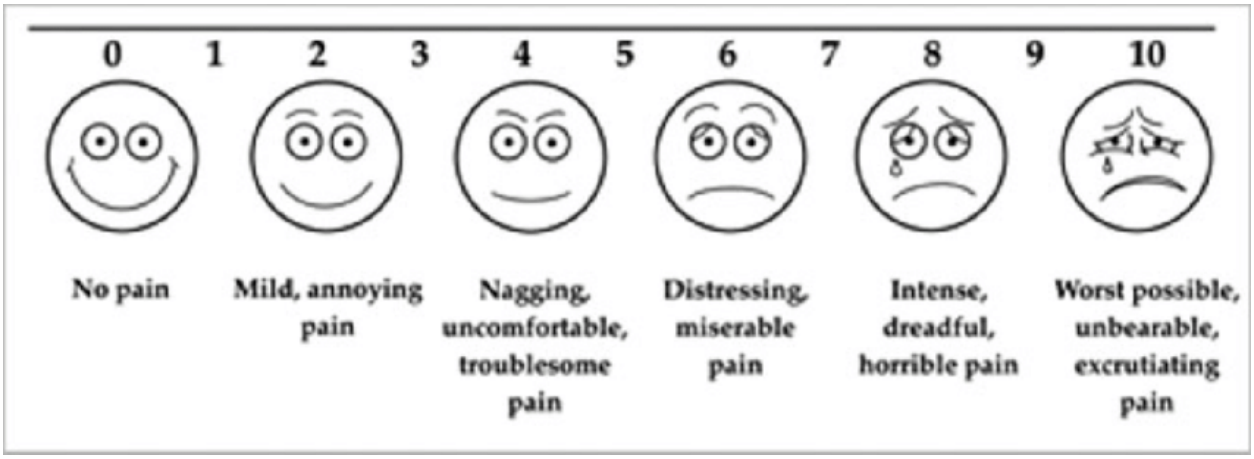
Reason for today's visit: _____

Which side hurts? Right Left **Hand Dominance: Right Left**

Pain Description:
Dull Sharp Tingling

When does pain occur?
At rest With Activity At Night

Pain Rating:



What reduces the pain? _____

What exacerbates the pain? _____

Injury? Yes No
If yes, what date: ___/___/_____

Work injury? Yes No

Is there an ongoing lawsuit? Yes No
If yes, name of law firm: _____

Mechanism:_____
_____

Have you had any treatment for this problem? If so, what?
_____
_____

Height: _____ Weight (in pounds): _____

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	Y	N	Heart Disease/Disorder	Y	N
Arthritis.....	Y	N	Lung Disorder.....	Y	N
Bleeding/Clotting Disorder....	Y	N	Liver Disease/Hepatitis	Y	N
Blood Pressure Disorder.....	Y	N	Neurological Disorder/Chronic Headaches	Y	N
Blood Transfusion	Y	N	Psychiatric Disorder/Illness.....	Y	N
Bowel/Stomach Problems.....	Y	N	Pulmonary Embolism/DVT.....	Y	N
Cancer.....	Y	N	Stroke.....	Y	N
Cholesterol Disorder	Y	N	Seizure or Epilepsy	Y	N
Diabetes.....	Y	N	Thyroid Disorder	Y	N
Eye Disorder.....	Y	N	Urinary/Kidney Disorder.....	Y	N
Gynecological Issues.....	Y	N	HIV/AIDS.....	Y	N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

_____

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition(s)	Living?	If deceased, what age?
Mother			
Father			
Sibling			
Other			

Do you currently smoke? Y N If no, previously? Y N
Years smoked Packs/day: _____ Do you use other tobacco products? Y N
Consume alcohol? Y N If yes, drinks/week: _____
Recreational Drug Use? Y N If yes, what kind? _____
If Relevant: Any past pregnancies? Y N How many? ___ How many deliveries? ____

Current Medications (include dose and over the counter medications):

_____
_____
_____
_____
_____

Allergies to Medications (please include reaction):

_____
_____
_____

Review of Systems:

Are you currently or have had problems with:			***Please explain/describe YES answers**
Hematological/ Bleeding problems	Yes	No	_____
Unexplained weight loss	Yes	No	_____
Skin	Yes	No	_____
Ear, Nose, Throat	Yes	No	_____
Stomach/Digestion	Yes	No	_____
Bowel/Bladder problems	Yes	No	_____
Musculoskeletal	Yes	No	_____
Neurological	Yes	No	_____
Psychiatric problems	Yes	No	_____
Fever/Chills	Yes	No	_____
Night Sweats	Yes	No	_____
Night pain/ Pain at rest	Yes	No	_____

PRECISION HAND AND UPPER EXTREMITY CENTER
Notice of Privacy Practices

This notice describes how health information about you (as part of this practice) may be used and disclosed, and how you can get access to your health information. Please review it carefully. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by law to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate officials.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions of law enforcement officials if you are an inmate or under the custody of a law enforcement official
8. For Workers' Compensation and similar programs

Your right regarding your health information

1. Communications. You can request that our practice communicate with you about your heath and related issues in a particular manner or at a certain location. We will accommodate all reasonable requests
2. You can request restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the practice. You must provide us with a reason that supports your request for an amendment.
5. Right to a copy of this notice at any time.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice.
7. Right to provide an authorization of other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are identified by this notice permitted by applicable law.

If you have any question regarding this notice or our health information privacy policies, please contact the practice. Precision Hand and Upper Extremity Center, 4461 Coit Rd, STE 101 Frisco, TX 75035.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices.

Signature: _____

Print Name: _____

Date: _____

Name of Patient (if minor): _____

PRECISION HAND AND UPPER EXTREMITY CENTER
Financial Policy

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions, please discuss them with one of our patient representatives. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Payment is due at the time of service unless other arangements have been made in advance. For your convenience, we accept cash, checks, major credit cards and care credit.
- **We reserve the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments that are not cancelled with a 24-hour advance notice. "No show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.**
- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we file your insurance claims for you if you assign benefits to a physician. If your insurance company does not pay within a reasonable period, you may be responsible for payment.
- We have made prior arrangements with many health plans to accept an assignment of benefits. If you are covered by one of these plans, as a courtesy we file to your insurance. At the time of service, payment is required upon the verification of your current benefits.
- All health plans are not the same. Some may not be able to find you under your insurance ID# and require a social security number of the policy holder in order to find the patient. Therefore, we require your social security number in able to file your insurance on your behalf. If you do not supply us with your social security number, you will be considered a private pay patient and you will be required to pay in full for services rendered. If you do not wish to pay in full for services rendered, your appointment will be cancelled.
- In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you **read your insurance booklet** or a copy of the contract your policy falls under to determine your benefits.
- You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents, or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable in full immediately.
- A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on our contract allowable, for scheduled surgical procedures. Any remaining balance, after your health plan pays, is your responsibility. Payment is due upon receipt of a statement from our office.
- Be prepared to present your insurance card and proof of identity at each visit. You will be responsible for providing a change of address, telephone number and/or insurance information anytime a change occurs.
- We will look to the adult accompanying a minor for payment of all services rendered to minor patients.

When you are charged a "global" fee for surgery or office care of a fracture, laceration repair, office procedure, etc., that fee not only includes the service on the day it is performed, but also includes routine follow-up care as well. The global period ranges from 10-90 days depending on the procedure and your health plan. X-rays and supplies, such as casting or dressing materials, splints, durable medical equipment, etc., are **NOT** included in the "global"period and charges will be made for these items. Services related to complications are also **NOT** included in the "global" period.

Patient Signature_____ Date: _____

PRECISION HAND AND UPPER EXTREMITY CENTER

CONSENT FOR TREATMENT

I understand that I have presented myself to Dr. Aimee Schimizzi, Precision Hand and Upper Extremity Center, Kyoto Medical Management, PLLC, and/or one of their affiliate entities for evaluation and/or treatment for my condition(s). I authorize and direct Dr. Schimizzito perform quality care upon me and understand that all options will be discussed prior to the administration of treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or any staff, associates, or colleagues.

_____ (Initial)

FACSIMILE AUTHORIZATION

I, the undersigned, authorize Dr. Schimizzi or one of the affiliate entities to send/receive confidential healthcare information as the term defined by HIPAA (Helath Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. I may revoke this authorization by giving the practice a five (5) day written notice. The revocation may be by facsimile transmission, however, a written copy of the revocation must be mailed to the clinic as well.

_____ (Initial)

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Schimizzi or one of the affiliate entities and any assisting physicians, PA, NP, RNFA for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

_____ (Initial)

ACKNOWLEDEMENT OF FINANCIAL INTERESTS

I understand that Dr. Aimee Schimizzi have a direct or indirect contractual relationship with or ownership interest in ("Relationship") Precision Hand and Upper Extremity Center, Kyoto Medical Management, PLLC, Coastal Bend Orthopaedic Specialists, PLLC, and Baylor Scott and White Sports Surgery Center at The Star and may benefit by referring me to these health care professionals or health care facilities. Some of these professionals or facilities may be out of network and as a result, I understand I may receive an out of network bill. I understand that I have the right to choose the provider of my health care services, and I am welcome to seek treatment from an alternative provider or at an alternative facility at any time. I will not be treated differently by Dr. Schimizzi or the practice or any of its affiliates if I choose to obtain health care services from an alternative provider or at an alternative facility.

_____ (Initial)

ACKNOWLEDGEMENT FORM

I have received and/or reviewed the Notice of Privacy Practices. I have received a copy of the financial policy for this practice and agree to adhere to its terms.

_____ (Initial)

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Patient Preference-Communication of Health Information

I hereby give permission to Aimee L. Schimizzi, MD, and Precision Hand and Upper Extremity Center to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s), and/or personal friend(s):

Name: _____ Relationship: _____

Telephone Number: _____

Name: _____ Relationship: _____

Telephone Number: _____

Name: _____ Relationship: _____

Telephone Number: _____

_____ I **DO NOT** wish to give permission for family member(s), other relative(s), and/or personal friend(s) to have access to any information related to my medical condition(s)

It is OK to leave detailed medical information on all phone # I have provided (circle one) Y/N

If not, please indicate which phone number(s) we can: Home Work Cell None

Patient Signature: _____ Date: _____

Printed Name: _____