NANCE MD

— Hand Surgery —

# ERIN NANCE M.D.

- Patient Registration
- Assignment of Insurance Benefits / No Litigation Agreement / e-Prescribing
- Financial Policy
- New Patient History and Intake Form

**800A FIFTH AVENUE SUITE 300 . NEW YORK.NY 10065-7215**
**P | 212.920.4106 F | 212.980.7888 WWW.NANCEMD.COM**

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## PATIENT INFORMATION (TAB TO ENTER INFORMATION)

| NAME | SSN# | SEX (“X”) M F |
|---|---|---|

| MARITAL STATUS S M D W DP | BIRTHDATE | AGE |
|---|---|---|
| STREET | CITY | STATE ZIP |
| CELL PHONE | OTHER PHONE | EMAIL |
| EMERGENCY CONTACT | EMERGENCY CONTACT’S PHONE | |
| REFERRING DOCTOR | PRIMARY CARE PROVIDER | |

## INSURANCE INFORMATION

| PRIMARY INSUR | SECONDARY INSUR |
|---|---|
| ID GROUP | ID GROUP |
| ADDRESS | ADDRESS |
| CITY STATE ZIP | CITY STATE ZIP |
| CO-PAYMENT $ DEDUCTIBLE $ | CO-PAYMENT $ DEDUCTIBLE $ |

| INSURED’S NAME **(IF RELATIONSHIP IS OTHER THAN SELF, PLEASE PROVIDE:)** | | |
|---|---|---|
| RELATIONSHIP | BIRTHDATE | INSURED’S SS# |
| STREET | CITY | STATE ZIP |

## EMPLOYMENT INFORMATION

| MY EMPLOYER | SPOUSE’S/PARENT’S EMPLOYER |
|---|---|
| ADDRESS | ADDRESS |
| CITY STATE ZIP | CITY STATE ZIP |
| MAIN NUMBER EXTENSION | MAIN NUMBER EXTENSION |
| OCCUPATION | OCCUPATION |

**ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.**

**I AUTHORIZE ERIN NANCE, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS.**

| **SIGNATURE** | **DATE (“MM/DD/YEAR”)** |
|---|---|

**PATIENT NAME:** _____ **DATE:** _____

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**INITIAL WHERE INDICATED TO CONFIRM ACKNOWLEDGEMENT**

**ASSIGNMENT OF BENEFITS (INITIAL HERE)** ☐

I request that payment of authorized insurance benefits (including Medicare, if I am a Medicare beneficiary) be made on my behalf to Erin Nance, MD for any medical services provided to me.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services rendered by Erin Nance, MD to my insurance carrier, Medicare, or other medical entity as necessary. A copy of this authorization will be sent to Medicare, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the Erin Nance, MD for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

By signing this document, I also acknowledge that I have been directed to the organization's Notice of Privacy Practices on http://www.nancemd.com/documents/privacypolicy.pdf

This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

**NO LITIGATION AGREEMENT (INITIAL HERE)** ☐

It is understood and agreed that my purpose of requesting examination and treatment is for medical purposes only and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide true and accurate copies of any medical records in the possession and control of this office pursuant to an authorization.

**E-PRESCRIBING (INITIAL HERE)** ☐

Erin Nance, MD utilizes e-Prescribing. Electronic Prescribing is a federally mandated initiative that requires all physicians prescribe in this manner effective 2011. Electronic Prescribing software sends prescriptions over the internet to your preferred pharmacy in a safe and secure way through the same technology used by credit card companies. This helps protect the privacy of your pesonal information.

Electronic Prescribing software also lets your doctors see important information such as drug interactions and your prescription history.

The benefit to you:

- Less confusion caused by handwritten prescriptions and unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to the pharmacy.
- A safer, faster, and easier way to get your prescriptions filled.

Patient Preferred Pharmacy

Complete pharmacy information below to indicate which pharmacy you would like your prescriptions sent.

Pharmacy Name _____

Phone Number _____

Address _____

_____

**NAME OF INSURED:** _____ **SSN#** _____

**PATIENT NAME** _____ **DATE** _____

**PARENT/GUARDIAN NAME (PRINT)** _____ **DATE** _____

**SIGNATURE (PATIENT/PARENT/GUARDIAN)** _____

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# FINANCIAL POLICY FOR ERIN NANCE MDPC

Thank you for choosing Erin Nance, MD as your health care provider. Our practice is committed to delivering the best treatment possible for each of our patients. Your clear understanding of our financial policy is important to our professional relationship, and allows us to concentrate on patient care.

## COMMERCIAL INSURANCE

We must emphasize that as your medical care provider, our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges from the date the service is rendered are your responsibility. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. If Dr. Nance participates with your medical insurance, please remember your co-payment is due at the time of service. This is a requirement of your insurance company. Please remember to have all necessary referrals completed prior to your appointment. If your insurance requires prior authorization or referral for any of your visits or treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all chargers incurred or your visit can be rescheduled.

If we do not participate with your insurance company, payment for office visits is due at the time of service. However, we will bill office visits and surgical procedures to this insurance for you as a courtesy. Please be aware that you will continue to receive statements from us until your account is paid in full. This will alert you that the insurance company has not yet sent payment to us on your behalf. Your insurance company may send the payment to you, the insured, not the physician. It is your responsibility to forward both the payment and the accompanying explanation of benefits to our office. This will enable our billing service to post accurate payments and reconcile your account. Your credit card on file will be used to process any balance that has not been paid by insurance.

## AHCCCS/MEDICAID

Dr. Nance is NOT CONTRACTED with ANY AHCCCS or STATE MEDICAID PLANS. By signing below, you agree to pay in advance all charges related to your treatment. Unless you have Medicare as primary coverage, we will not submit claims to AHCCCS or any other state Medicaid plan.

## WORKERS COMPENSATION

If you have an open, accepted Worker's Compensation claim, you are required to provide us with all necessary insurance information. Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment from the patient will be expected until the practice is provided with all the information necessary to submit a claim.

## PERSONAL INJURY OR AUTO ACCIDENT (NO FAULT) CLAIMS

Unless we have a signed lien on file, you are responsible for payment at the time of service. If applicable, we will bill your private medical insurance. If we are contracted with your insurance plan, there may be a difference between what we bill and what the insurance company allows. When there is a third party claim, most insurance plans allow us to balance bill the patient.

## SURGICAL PROCEDURES

If you are recommended for surgery, our staff will calculate your coinsurance and unmet deductible amounts: 50% of this amount will be collected as a surgery deposit, and the remaining 50% is due on or before the day of surgery. Payment plans are available through CareCredit - see **Forms of Payment**.

## CANCELLED APPOINTMENTS

It is important that you keep your scheduled appointments. If you are unable to do this, please call the office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged $50.00.

## CANCELLATION AND RESCHEDULING OF SURGERY

We understand that a situation may arise that could force you to cancel or reschedule your surgery. Depending on the circumstances you maybe assessed a fee of $300 for cancelling surgery. The fee assessed for rescheduling of surgery is $150. These fees will not be applied toward your surgery and will be added as a charge to your account, not billable to insurance.

## FORMS AND OTHER PAPERWORK

Disability/FMLA or other forms requiring physician/staff review for completion will require a payment of $20 for the first form. Each additional form will incur a $40 fee.

## FORMS OF PAYMENT

We accept cash, checks (with proper identification), and credit cards. We also accept CareCredit health care financing options towards payment for surgical procedures. To learn more about financing your surgical procedure with CareCredit please ask a representative at the office. If we do not have a copy of your most current insurance card on file, you will be considered a self-pay patient and will be expected to pay at the time of service. Please remember to bring your insurance card with you to each appointment.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing office promptly for assistance in the management of your account. If you have any questions or need any additional information regarding our financial policy, please do not hesitate to call our billing office at (718) 313-0027.

## DEPENDENT CHILDREN

The responsibility of payment for services rendered to any dependent children whose parents are divorced rests with the parents who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of the Practice.

## X-RAYS AND LAB STUDIES

Lenox Hill Radiology/Radnet provides X-ray services in our office. You will be billed directly by them for services rendered. If we order laboratory tests or special x-rays that are not taken in our office, you will be billed directly by the lab or xray facility. You are responsible for payment of that bill. If your insurance company requires for you to go to a particular facility, please let us know. Please advise us if your insurance company requires pre-certification/authorization for tests, x-rays, surgeries, physical therapy, etc.

**I have read and understood the above financial policy.**

**PATIENT NAME** _____ **DATE** _____

**PARENT/GUARDIAN NAME (PRINT)** _____ **DATE** _____

**SIGNATURE (PATIENT/PARENT/GUARDIAN)** _____

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# NEW PATIENT HISTORY AND INTAKE FORM

## Patient Information

Patient Name: _____ Date of Birth: _____

Date of Visit (Today's Date): _____ Date of Injury (if applicable): _____

How did you hear about Dr. Nance? : Google Search ZocDoc Practice Website

If you were referred by a friend or doctor, please list them: _____

Height: (inches)_____ Weight: (lbs.)_____

Medications (please list all current medications or check option which applies):

I brought a copy of my medication list (please provide the list to the front desk receptionist)

**Not currently taking any medications**

| Medication Name | Dosage | # times dosage taken per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Allergies (please list all known allergies or check option which applies):

I brought a copy of my allergy list (please provide the list to the front desk receptionist)

**No known allergies**

| Allergy Type | Please describe allergic reaction severity and symptons |
|---|---|
| | |
| | |

Past Medical History (Please List):

_____

_____

_____

**NO Past Medical History**

Past Surgical History (Please list):

_____

_____

_____

**NO Past Surgical History**

Past Orthopedic History (Please List):

_____

_____

_____

**NO Orthopedic History**

| PATIENT NAME: _____ | DATE: _____ |
|---|---|

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# NEW PATIENT HISTORY AND INTAKE (CONT'D)

Family History (Please List):

_____

_____

_____

☐ **NO Family History (checking this box indicates no past family medical history)**

Social History (please check all that apply):

| Cigarette Smoking | Alcohol Use | Exercise Frequency |
|---|---|---|
| ☐ Never Smoked | ☐ Do not drink alcohol | ☐ Several times a day |
| ☐ Quit: former smoker | ☐ Less than 1 drink a day | ☐ Once a day |
| ☐ Smokes less than daily | ☐ 1-2 drinks a day | ☐ Few times a week |
| ☐ Smokes daily | ☐ 3 or more drinks a day | ☐ Few times a month |
| o # packs per day_____ | | ☐ Never |
| o Total years smoking:_____ | | Other_____ |

Occupation and Workplace: _____

Were you referred from an ER or Urgent Care facility? ☐ Yes ☐ No

Which side is your problem? Right Left Bilateral

Where is your problem? (Please Circle) Finger: ( Thumb Index Middle Ring Small) Hand Wrist

Forearm Elbow Upper Arm Shoulder Other:_____

What is the main symptom? Pain Numbness/Tingling Stiffness Weakness Clicking

Other:_____

Hand Dominance: Right Left Ambidextrous

How did your symptoms start? (Check all that apply)

| | |
|---|---|
| ☐ Gradual and insidious onset | ☐ Playing a sport |
| ☐ With activities of daily living | ☐ Repetitive motion at work |
| ☐ Falling onto an outstretched hand | ☐ Trauma:_____ |
| ☐ Injury at work | ☐ Other: _____ |

Describe your symptoms. (Check all that apply)

| | | |
|---|---|---|
| ☐ Aching | ☐ Pins and needle-like | ☐ Improving |
| ☐ Burning | ☐ Radiating | ☐ Staying the same |
| ☐ Catching/clicking | ☐ Sharp | ☐ Worsening |

What aggravates or alleviates your symptoms? (Check all that apply)

| | |
|---|---|
| ☐ Improves with pain medication | ☐ Worsens with exercise |
| ☐ Improves with physical therapy | ☐ Worsens with movement |
| ☐ Improves with rest | ☐ Other:_____ |

| PATIENT NAME: _____ | DATE: _____ |
|---|---|

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# NEW PATIENT HISTORY AND INTAKE (CONT'D)

Describe the timing of your symptoms. (Check all that apply)

| | |
|---|---|
| ☐ Began today | ☐ Occurs intermittently |
| ☐ Constantly occurs | ☐ Occurs randomly |
| ☐ Occurs at night | ☐ Occurs with activity |
| ☐ Occurs in the morning | ☐ Other:_____ |

How severe are the symptoms? (None) 0 – 10 (most severe): _____

How long have you had the symptoms? Years_____ Months_____ Weeks_____ Days_____

What are you currently using to treat the symptoms? (Check all that apply)

| | |
|---|---|
| ☐ **NO treatment** | ☐ Narcotics |
| ☐ Brace / Cast / Splint | ☐ NSAIDS / Tylenol |
| ☐ Injection of steroid | ☐ Physical Therapy |

What diagnostic imaging studies have you had for this problem? (Check all that apply)

| | |
|---|---|
| ☐ **NONE** | ☐ CT Scan |
| ☐ X-Ray | ☐ Nerve Conduction Study / EMG |
| ☐ MRI | ☐ Other:_____ |

How has this problem limited you? (Check all that apply)

| | |
|---|---|
| ☐ **NO limitations** | ☐ Inability to work / Working light duty |
| ☐ Difficulty with everyday activities | ☐ Requiring occasional assistance |
| ☐ Difficulty with recreational sports | ☐ Other:_____ |

Who have you seen for this problem? (Check all that apply and name)

| | |
|---|---|
| ☐ Another orthopedist | ☐ Trainer |
| ☐ Emergency Room | ☐ Urgent Care Center |
| ☐ Primary Care doctor | ☐ Other:_____ |

Review of Systems* (check yes or no if you are currently experiencing any of the following):

| Symptom | Yes | No |
|---|---|---|
| Joint Swelling | ☐ | ☐ |
| Numbness | ☐ | ☐ |
| Easy bleeding | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |

Alerts* (Check all items that pertain to you):

| | |
|---|---|
| ☐ Blood Thinners | ☐ Allergy to shellfish / iodine |
| ☐ Pacemaker | ☐ Allergy to Latex |
| ☐ Defibrillator | ☐ Allergy to Adhesive |
| ☐ Premedication prior to procedures | ☐ Under pain management |
| ☐ Rheumatoid Arthritis | ☐ Pregnant or planning to become pregnant |
| ☐ RSD / Complex Regional Pain Syndrome | |

Have you or are you planning to apply to disability? ☐ Yes ☐ No

Is there a lawsuit or litigation pending in relation in your injury? ☐ Yes ☐ No

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concern