



Welcome To Our Office!

Patient Name: _____ Today's Date: _____		
First	Middle	Last
Home Address: _____		
City: _____		State: _____ Zip: _____
Telephone: () _____		Birth Date: _____ Age: _____
Cell: () _____		SSN: _____
Employer: _____		Work Phone: () _____
Employer's Address: _____		
City: _____		State: _____ Zip: _____
Marital Status: M S D W		

Responsible Party if patient is a minor

Name: _____ today's Date: _____		
First	Middle	Last
Home Address: _____		
City: _____		State: _____ Zip: _____
Telephone: () _____		Birth Date: _____ Age: _____
Cell: () _____		SSN: _____
Employer: _____		Work Phone: () _____
Employer's Address: _____		
City: _____		State: _____ Zip: _____

[Primary Insurance]

Name of Insurance Company: _____		
Insured's Name: _____		SSN: _____ DOB: _____
Insured's ID # _____		Group # _____
Employer: _____		Work Phone: () _____

[Secondary Insurance]

Name of Insurance Company: _____		
Insured's Name: _____		SSN: _____ DOB: _____
Insured's ID # _____		Group # _____
Employer: _____		Work Phone: () _____

In case of emergency, contact: _____		Relationship: _____
Home Phone: () _____		Work Phone: () _____

Referring Dr. _____	
Primary Dr. _____	
Preferred Pharmacy _____	Telephone # _____



**NORTH TEXAS
HAND CENTER, P.A.**

Patient's Name: _____ Today's Date: _____
First Middle Last

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts at the time services are rendered unless other payment arrangements have been made. Any outstanding balances that are turned over to our collections agency will have a 33% increase to cover any administrative costs. _____(initial)

I understand that I will be charged a \$10 fee for any administrative paperwork, disability forms, FMLA, no show appointments, copies of medical records, etc... _____ (initial)

Should it be decided that surgery is necessary I understand that I will be required to pay \$300 prior to the procedure, depending on my insurance deductible and co-insurance _____ (initial)

Should it be required that a brace, splint or other durable medical equipment is prescribe by the physician, I understand that due to sanitary reason the item is non-returnable. I also understand that these items may not be covered by my insurance company. _____ (initial)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Dr. Stuart M. Hilliard** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Dr. Stuart M. Hilliard** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Dr. Stuart M. Hilliard**.

I acknowledge that I have been given, upon request, the **North Texas Hand Center, P.A.** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Responsible Party: _____ Date: _____

Please complete the Workers Compensation for claims billing purposes.

Did your injury happen on the job? Yes No if yes, on what date did the injury occur? _____

Did you report the accident to your employer? Yes No

Employer Contact Name _____ Telephone: _____

Name of Insurance Company: _____

Adjusters Name: _____ Telephone: _____

SSN: _____ Date of Injury: _____ Claim # _____