PATIENT REGISTRATION FORM

Please take a few minutes to complete this form. There may be times when it is urgent that we contact you, so please try to be as complete and accurate as possible, especially with phone numbers. All information provided is completely confidential. Thank you for choosing our Team! Dr. Carmella Fernandez, MD MBA

Name: ____
First Middle Last

Mailing Address: ____
Street # Street Name Apt. #

____ Home Phone: ________________
City State Zip

SSN: ______-_______-______ DOB: ________________ Cell Phone: ____________________

Race: ______________ Ethnicity: _____________ Preferred Language: ____________
(Hispanic, Non-Hispanic or Declined)

Marital Status: Single Married Separated Divorced Widowed

Reason for visit today: ____________________ Referred By: _______________________
(Internet, phonebook, physician)

Employer Name: ____________________________ Phone number: ___________________

________________________________ ___________________ _______________
City State Zip

(Please skip if you have provided updated insurance cards/information to our front desk staff)

Primary Insurance Carrier:

__________________________ ID#: _____________________

_____________________________ _____________ _________________________
Subscriber Name (if different from patient) DOB Relationship to Subscriber

Secondary Insurance Carrier: ____
(if applicable)

Pharmacy Name: ____

City & Cross Street: ____________________________ Phone Number: ___________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Fernandez Upper Extremity Institute or insurance company to release any information required to process my claims.

Signature: ____ Date: ___________________

Fernandez Upper Extremity Institute
730 Goodlette RD N
STE 204
Naples FL 34102
PH# 239-777-9321
FX# 239-330-7930
https://carmellafernandezmd.com/

“No Show” and “Cancellation” Policy for Office Visits, In-Office Procedures and Surgery

(In compliance with the American Medical Association Policy)

(Please read carefully as these policies are reinforced)

At Fernandez Upper Extremity Institute, our goal is to provide quality upper extremity and orthopedic care in a timely manner to all our patients. Please be courteous and call **FUEI** promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. As a courtesy, and to help patients remember their scheduled appointments, Fernandez Upper Extremity Institute’s office calls a day prior to your scheduled appointment as well as sends email reminders.

The following policy is about patients who fail to keep their scheduled office visit appointment, procedure appointment or scheduled surgery appointment.

In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

1. Patients who **fail to show for their scheduled appointment** or did not notify the office within 24 hours of their scheduled appointment time to cancel, shall be **subject to a “No Show/Cancellation” fee of $100.00.**
2. If you are **10 minutes or more late to your scheduled appointment, you will be rescheduled and a NO SHOW FEE will be applied to your account.** After **three consecutive no-shows to your appointments, our practice will terminate its relationship with you**.
3. Patients who **fail to show for their scheduled in-office procedure appointment** or did not notify the office within 48 hours of their scheduled appointment time, shall be **subject to a “No Show/Cancellation” fee of $150.00.**
4. Patients who **fail to show for their scheduled surgery appointment or electively cancel their surgery** within 72 hours of their scheduled surgery appointment time, shall be **subject to a “No Show/Cancellation” penalty of $250.00, and any surgery deposit WILL NOT be refunded.**. If cancelled by the physician as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.
5. Surgery **deposits are collected at the time of scheduling and up to 2 days prior to procedure and will be refunded once all disputes are FINAL and payment from your insurance has been received and applied to your account. Failure to pay will result in surgery cancellation.**

These fees are not covered by insurance and is therefore the sole responsibility of the patient.
To cancel or reschedule appointments call our office at 239-777-9321. If you have any problems getting through, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

Acknowledgment:

I hereby acknowledge **receipt and have reviewed Fernandez Upper Extremity Institute’s** “No Show” and “Cancellation” Policy for Office Visits, In-Office Procedures and Surgery. I understand that **FUEI** reserves the right to change its privacy practices that are described in that Notice. I also understand that any Revised Notice will be available at our office, website and or mailed upon request.

____

Patient Name Signature Date

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HIPAA NOTICE PRIVACY PRACTICE

Patient Name: ____ DOB: _______________

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition, and related health care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and the conducting or arranging for other business activities. For example, we may disclose your protected health sheet at the register desk where you will be asked to sign your name and indicate your physician/practitioner. We may also call you by name in the waiting room when your physician/practitioner is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situation without your authorization. These situations include as required by law: Public Health issues: Communicable Diseases: Health Oversight, Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the Law, we must make disclosures to you when and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures:
These will only be made with your Consent, Authorization or Opportunity to object, unless required by law.

Revocation:
You may revoke this authorization, at any time, in writing, except to the extent that your physician/practitioner the medical practice has taken an action in reliance on the use or disclosure indication in the authorization.

Your signature below is only an acknowledgement that you have received this Notice of our Privacy Practices

____

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Patient Name: ____________________________________ DOB: _______________

Financial Responsibility

I acknowledge full financial responsibility for services rendered by **FERNANDEZ UPPER EXTREMITY INSTITUTE**.

I understand that I am responsible for prompt payment or any amounts due including, but not limited to: co-pays, deductibles, and coinsurance amounts. **I understand that payment of co-pays, deductibles and coinsurance amounts are expected at time of service, as well as any prior balances I may owe. Please note that we DO NOT accept personal checks and Care Credit as payment in our office. For your convenience we DO accept major credit card companies such as VISA, MasterCard, American Express, Discover.**

- I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to **Fernandez Upper Extremity Institute** for any medical and/or imaging, and/or surgical services furnished. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges.

Financial Policy Outline:

(Please read carefully as these policies are reinforced)

1. ***Know your insurance plan and what your covered benefits are*. You will be responsible for any remaining balances that your insurance does not cover. You may also receive separate charges from other facilities.**
2. As a courtesy, we will verify your benefits and bill your insurance for services rendered. **You will be responsible at the time of service for payment of annual deductibles, co-payments, co-insurance costs, payments due in full, and charges for services not covered by your insurance.**
3. **We do not accept checks as a form of payment.**
4. There is a $30 fee to fill out forms. **Excluding:** work notes, school excuses, DWC-25.
5. Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.
6. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **SELF-PAY: If you do not have group or medical insurance, payment for all professional services is expected at the time of your visit. Please note, we DO offer discounted fees for patients without health insurance.**
8. **NON-PAYMENT: All patients responsible balances that remain delinquent after 90 days, with no response to our request for payment, will be referred to a collection agency. Please be aware that if a balance remains unpaid, you and/or your immediate family member may be discharged from this practice.**

Assignment & Release:

I hereby assign my insurance benefits to **Fernandez Upper Extremity Institute.**

Any overpayment will be refunded to the insured as soon as final payment by insurance has been received and posted to the respective account.

I am financially responsible for charges which are not paid by the insurance carrier.

I hereby authorize Fernandez Upper Extremity Institute to release any information acquired in the course of my examination or treatment to my referring physician, any physician involved in my treatment, or to my insurance company.

I hereby authorize photocopies of this form to be as valid as the original.

____

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PATIENT/CLIENT/PARTICIPANT CODE OF CONDUCT

(Please read carefully as these policies are reinforced)

Fernandez Upper Extremity Institute adopts this Code of Conduct in order to define acceptable standards of behavior for patients/clients/participants (referred to as Patient within the remainder of this protocol) and to provide a procedure for action whenever there are grounds to suspect that a patient has engaged in disruptive or unacceptable behavior.
All patients, as a condition of their continued treatment by a FUEI provider, will abide by FUEI rules, regulations, policies, and all other lawful standards.

The code of conduct also applies to chaperones and caregivers who may bring the patient into the office for their appointments.

1. Patients will treat all staff members with respect with words, body language, or gestures.
2. Patient will refrain from any form of violence (verbal, sexual, or physical) to any person. This includes sexual, ethnic, or other types of harassment, whether verbal or physical in nature.
3. Patient will be honest and factual with all communication with FUEI staff
4. Patients will be considered non-compliant for repeated and/or deliberate violation of FUEI rules or policies.
5. **Possession of illicit drugs or alcohol on the premises is not allowed**.
6. Legal prescriptions and over the counter drugs may be brought on premises and used in their prescribed manner.
7. Our centers are smoke free.
8. **Weapons (including but not limited to firearms) are not allowed within our buildings**
9. **Attending sessions/appointments "under the influence" may be grounds for restriction of privileges, rights, and services, or termination/discharge**.
10. Persons believed to be under the influence at any FUEI facility will be given the opportunity to call someone to pick them up, or transportation will be arranged by our staff. If they leave the facility driving a vehicle, law enforcement will be notified.

REPORTS OF DISRUPTIVE BEHAVIOR

If any individual working at FUEI reasonably believes that a patient is engaging in disruptive behavior or has broken our Code of Conduct protocol, he or she may discuss directly with the client/patient, document the incident, and advise their immediate supervisor as soon as possible.

ACTION

1. The Site Manager/Clinic Director will review the information provided.
2. Site Manager/Clinic Director will interview all staff involved, as well as the patient, chaperone, and caregiver.
3. **If patient is determined to be in non-compliance with the patient code of conduct, he or she may be discharged or terminated from the practice**

Patient Name: ____ DOB: _______________

____

Patient Signature Date

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CONSENT TO LEAVE MESSAGES AND AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Patient Name: ____ DOB: ________________

We are unable to discuss your treatment with anyone unless you give us written permission.

Please complete the information and sign below to verify your permission. Please circle all that apply and fill in the blanks:

[ ] I authorize the release of information including the diagnosis, records, images, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse Name & Phone Number: ____
[ ] Child(ren) Name(s) & Phone Number: ____
[ ] Parent Name & Phone Number: ____
[ ] Other Name & Phone Number:: ____

[ ] Information **IS NOT** to be released to anyone. (please note that ANYONE including family or friends WON'T have access to any of your information, including but not limited to confirmation of appointments).

This release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call my [ ] home [ ] work [ ] cell Number: ___________________________
If unable to reach me:

[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] Other ____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Fernandez Upper Extremity Institute or insurance company to release any information required to process my claims

____

Patient Signature Date

REVIEW OF MEDICAL HISTORY

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Date: ________________________

Name: ____ **Date of Birth:** _______________________

Height: ___________ **Weight:** __________lbs

Allergies

Do you have any allergies to medications? ☐ YES ☐ NO If yes, please list here

____

Habits/Exposures

Do you smoke? ☐ YES ☐ NO How many packs per day? _____________ How many years have you smoked? ____________

Do you drink alcohol? ☐ YES ☐ NO If yes, how much per day? _____________

☐ Other Drugs: ________________

Are you currently taking any medication? ☐ YES ☐ NO If Yes please list below: **(skip if you provided medication list)**

____

____

____

____

____

General Physical Conditions or Problems

Do you have any problems with any of the following? If yes, please list below:

Hearing, Eyes, Ears, Nose, Throat	☐ YES ☐ NO	Hepatitis or any kind of liver ailment or jaundice	☐ YES ☐ NO
Heart problems, or high blood pressure	☐ YES ☐ NO	Kidney or bladder problems/leaking of urine	☐ YES ☐ NO
Lung problems/Asthma/Bronchitis	☐ YES ☐ NO	Anemia/blood disorder/transfusion	☐ YES ☐ NO
Breast lumps/pain/nipple discharge	☐ YES ☐ NO	Thyroid/diabetes/other endocrine problems	☐ YES ☐ NO
Stomach/bowel/gall bladder problems	☐ YES ☐ NO	Headaches/migraines/nervous disorder	☐ YES ☐ NO
Varicose veins or phlebitis	☐ YES ☐ NO	Chicken Pox	☐ YES ☐ NO

☐ Other ____

Previous Surgeries:

____

____

____

Family History

Does anyone in your family have the following? If yes, who?

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High Blood Pressure ☐ YES ☐ NO ______________

Heart Problems ☐ YES ☐ NO ______________

Diabetes ☐ YES ☐ NO ______________

☐ Other: ____

Stroke ☐ YES ☐ NO ________________

Kidney Problems ☐ YES ☐ NO ________________

Hepatitis/TB/or infectious disease ☐ YES ☐ NO _________

Parents alive or deceased: ☐ YES ☐ NO Family history of gout or rheumatoid arthritis: [ ] YES [ ] NO

____

Patient Signature Date

(If you are not the patient, please specify your relationship to the patient)

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CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

__________ **(Patient initials)**

I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

__________ **(Patient initials)**

I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number: __________-_________-___________

Email: ____

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the following Email Address:

Email: ____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

Patient Name: ____ DOB: _______________

____

Patient Signature   Date

(If you are not the patient, please specify your relationship to the patient)

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effective 9/1/2019