Dr Sonya M Clark 1702 Skylyn Drive Spartanburg, SC 29307

NAME:_____ AGE:_____

OCCUPATION_____ DOMINANT SIDE: RIGHT LEFT

WHAT ARE YOU BEING EVALUATED FOR:_____

HAVE YOU PREVIOUSLY HAD SURGERY ON THE AFFECTED AREA? YES OR NO

IF YES, EXPLAIN?_____

WHERE IS YOUR PAIN? (DIAGRAM ON LAST PAGE)

RATE YOUR PAIN: (0=NO PAIN, 10=WORST PAIN IN YOUR LIFE) 1 2 3 4 5 6 7 8 9 10

WHEN DID YOUR PAIN START? ____/____/____ WAS THERE AN INJURY? YES OR NO

DID YOUR PAIN/SYMPTOMS OCCUR AFTER AN ACCIDENT? YES OR NO

CAR ACCIDENT WORK ACCIDENT SLIP/FALL (CIRCLE ALL THAT APPLY)

ARE YOU INVOLVED IN A LAW-SUIT IN REGARDS TO THIS INJURY? YES OR NO

LAWYER:_____

ARE YOU FILLING A DISABILITY CLAIM, IN REGARDS TO THIS INJURY? YES OR NO

HOW WOULD YOU DESCRIBE YOUR PAIN: (CIRCLE ALL THAT APPLY)

SHARP, STABBING, ACHING, THROBBING. BURNING

DOES ANYTHING RELIEVE YOUR SYMPTOMS: (CIRCLE ALL THAT APPLY)

REST, BRACE, NDSIDS (IBUPROFEN, ALEVE, CELEBREX), INJECTIONS

HAVE YOU HAD ANY TESTS FOR THIS PROBLEM. (CIRCLE ALL THAT APPLY)

X-RAY, NERVE CONDUCTION STUDIES (NCS) EMG, MRI

WHERE DID YOU HAVE THE TESTS?_____ WHEN?_____

ONLY FILL OUT SECTIONS THAT APPLY TO YOUR SYMPTOMS

HAND:

DO YOUR FINGERS GO NUMB OR TINGLE: YES OR NO

WHICH FINGERS?: THUMB INDEX MIDDLE RING SMALL

DO YOU WAKE UP WITH NUMNBNESS OR PAIN? YES OR NO

HAVE YOU WORN A BRACE FOR THIS PROBLEM? YES OR NO DID IT HELP? YES OR NO

HAVE YOU HAD A STEROID INJECTION FOR THIS PROBLEM? YES OR NO

WHEN? HOW MANY TOTAL?

DO YOUR FINGERS HURT? YES OR NO

WHICH FINGERS?: THUMB INDEX MIDDLE RING SMALL

WHICH JOINT HURTS? CIRCLE ON DIAGRAM

WHICH ACTIVITIES BOTHER YOU? (CIRCLE ALL THAT APPLY)

WRITING, OPENING A JAR, PINCHING, OPENING DOORS, TURNING KEYS

WRIST:

DOES YOUR WRIST HURT? YES OR NO WHERE IS YOUR WRIST PAIN? CIRCLE ON DIAGRAM

HAVE YOU WORN A BRACE FOR YOUR WRIST PAIN? YES OR NO

DID THE BRACE HELP WITH PAIN? YES OR NO

DO YOUR FINGERS GO NUMB? YES OR NO

ELBOW:

DOES YOUR ELBOW HURT? YES OR NO WHERE IS YOUR PAIN? CIRCLE ON DIAGRAM

DOES YOUR PAIN RADIATE? YES OR NO WHERE DOES IT RADIATE? (CIRCLE ALL) SHOULDER HAND

HAVE YOU HAD INJECTION INTO YOUR ELBOW? YES OR NO DID THE INJECTION HELP? YES OR NO

CAN YOU STRAIGHTEN AND BEND YOUY ELBOW WITHOUT DIFFICULTY? YES OR NO

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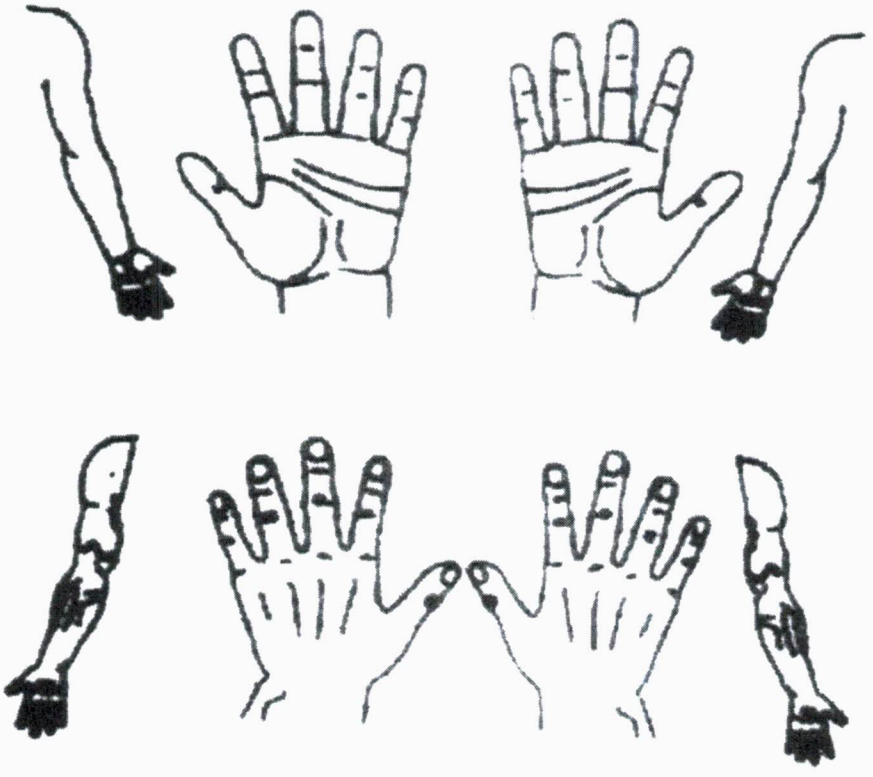
SHOULDER:

DO YOUR SHOULDERS HURT? YES OR NO
DOES IT HURT TO MOVE YOUR SHOULDER? YES OR NO
CAN YOU RAISE YOUR ARM ABOVE YOUR HEAD? YES OR NO
DOES YOUR SHOULDER PAIN WAKE YOU UP AT NIGHT? YES OR NO
DOES YOU HAVE NUMBNESS IN THIS ARM? YES OR NO
DOE YOUR NECK HURT? YES OR NO
DOES YOUR SHOULDER PAIN RADIATE? YES OR NO
WHERE DOES IT RADIATE? NECK ELBOW HAND
HAVE YOU HAD A STEROID INJECTIONS IN YOUR SHOULDER? YES OR NO
WHEN WAS YOUR LAST INJECTION? ____/____/____
HAVE YOU HAD PHYSICAL THERAPY FOR YOUR SHOULDER? YES OR NO
DID IT HELP? YES OR NO
HAVE YOU HAD ANY SPECIAL TEST ON YOUR SHOULDER? YES OR NO
IF YES, WHAT TEST? MRI CT SCAN EMG/NCS

DIAGRAM

LEFT HAND **RIGHT HAND**



Signature:_____ Date:_____

Dr. Sonya M Clark

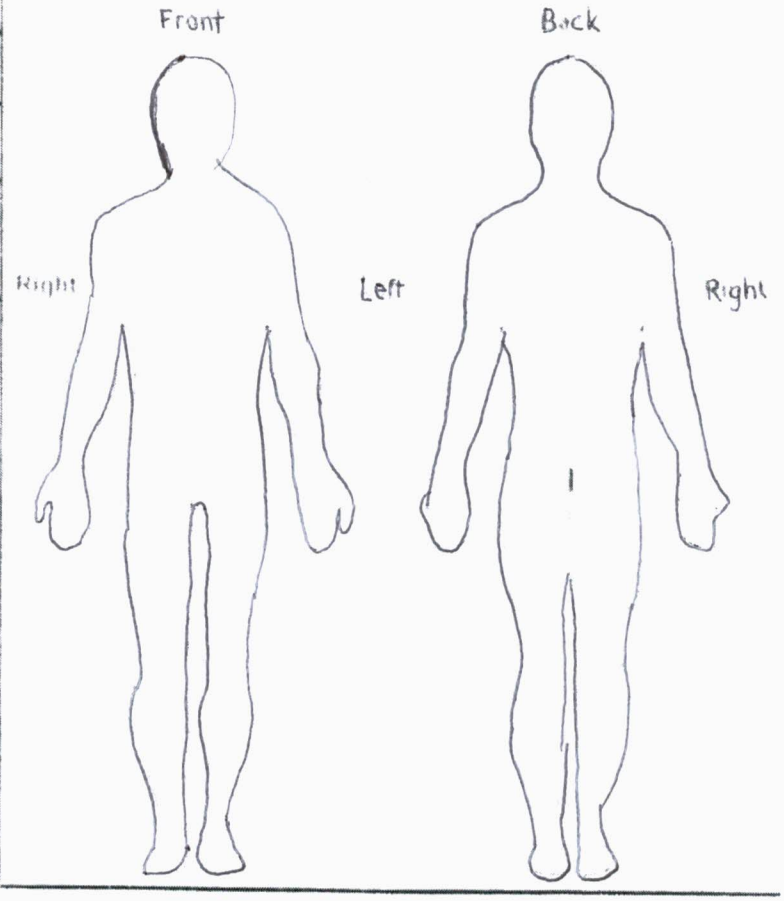
1702 Skylyn Drive Spartanburg, SC 29307

ONLY FILL OUT THE SECTIONS THAT APPLY TO YOUR SYMPTOMS

SPINE AND LOWER EXTREMITY

Where is your pain?	Lumbar Low Back	☐	Cervical Spine	☐	Thoracic Spine	☐
	Knee	☐	Ankle	☐	Foot	☐

Do you have Difficulty walking because of your problem?	YES or NO
Do you have to use an assist device to walk?	YES or NO
Do you have any numbness in your leg or arm or perineal areas?	YES or NO
Do you have any changes in bowel or bladder function?	YES or NO
If yes, since when. _____	



Signature: _____ Date: _____

Patient Registration Sheet

Last Name:_____ First Name:_____ M.I._____

Street Address:_____

City:_____ State:_____ Zip_____ DOB: _____

Phone Number:_____ home/Cell _____work

Sex: Male Female SS #: _____ Marital Status: Single Married Other

Employer :_____ Phone # _____

Insurance Company:_____ Policy #_____

Emergency Contact:_____ Phone # _____

Responsible Party Information

Relationship to Patient_____ If different please fill out the following information

Last Name:_____ First Name:_____ M.I._____

Street Address:_____

City:_____ State:_____ Zip_____ DOB: _____

Phone Number:_____ home/Cell _____work

Sex: Male Female SS #: _____ Marital Status: Single Married Other

Employer :_____ Phone # _____

Authorization to Release Information

I authorize release of information (including facsimile transmission) relative to my medical records and/or lab results to my referring physician _____, my spouse_____

and the following names only _____

Patient's or Authorized Persons Signature:

I authorize Dr. Sonya Clark to release any medical or other information necessary to process this claim. I also request payment of government benefits or other medical benefits assigned to Dr. Sonya Clark for any procedures and/or services rendered.

Signature:_____ Date: _____

Consent to Treat

I _____ (patient name) give permission for **Upstate Hand Center** to give me medical treatment.

I allow **Upstate Hand Center** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Upstate Hand Center** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Notice of Privacy Acknowledgement

We keep a record of all healthcare services we provide to you. You may ask to see and receive a copy of those records at any time. Any errors you discover on said records, you may request for correction to be made. If it is found to be in fact an error, corrections to those records will be made.

We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information by contacting our Privacy Office Administrator. Our Notice of Privacy describes in more detail how your health information may be used and disclosed and how to access your information.

By your signature below, you consent to treatment and acknowledge receipt of this Notice of Privacy Practices.

_____ _____

Patient's Signature: Date:

UPSTATE HAND CENTER

Patient Name: _____

FINANCIAL POLICY

PLEASE READ ALL INFORMATION AND ACKNOWLEGE BY SIGNING BELOW

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with correct information to bill your insurance.
2. If you have a change of address, telephone number, or employer, please notify the receptionist
3. Deductibles, co-payments or charges for non-covered services are due at the time of service. We accept cash and major credit cards.
4. You are expected to provide payment for previous balances or balances sent to collection prior to your office visit. If you are unable to pay your balance in full, contact the office at (864)308-8668, or talk to the receptionist to set up a payment agreement.
5. If your plan requires prior authorization, you must obtain the authorization prior to your visit at Upstate Hand Center.
6. SELF-PAY PATIENTS: Patients with no insurance are expected to pay at the time of service. A discount is offered for payment in full at the time of service. If you can't pay in full, a payment agreement must be made, prior to seeing the doctor.
7. **No show and missed appointments. If you do not give 24 hours' notice prior to cancellation, or rescheduling, you will be charged a $50.00 No-show/rescheduling fee. When an appointment is scheduled with the doctor, time is specially allocated for you. We ask as a courtesy phone call to cancel your appointment 24 hours in advance.**

Remember, whether you do or do not have insurance, you are ultimately responsible for payment of your charges. If you have any questions regarding our financial policy, please contact the office at (864)308-8668.

I have read and have a full understanding of the financial policy of Upstate Hand Center.

Signature: _____ ***Date:*** _____

Upstate Hand Center

1702 Skylyn Drive, suite A

Spartanburg, SC 29307

(864)308-8668

Pain Management Agreement

I voluntarily request that my physician treat my painful conditions. I hereby authorize and give my consent to prescribe controlled medications as an element in the treatment of my pain. It has been explained to me that these medication(s) may include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I agree with the following terms:

1.I understand that I am being treated by Upstate hand Center (henceforth referred to as UHC) and I agree to actively participate in all treatment as recommended and to keep all appointments as scheduled.

2.I will use controlled substances only as directed by UHC medical staff and will refrain from using any illicit drugs while on these medications and/or **I will notify UHC staff that I am under a separate pain management agreement and will not receive narcotics from this practice.**

3.I will receive controlled substances only from the UHC medical staff, except in the case of a medical emergency. I agree to inform my other doctors that I am receiving these medications and request that.

4. I agree to UHC informed of all medications that I am taking.

5. I understand that the most common side effects that could occur in the use of the medications in my treatment may include but are not limited to: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention(inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, low testosterone levels, tolerance to medication (s), physical and emotional dependence or even addiction and death.

6. I understand that controlled substances may cause physical dependence and that sudden withdrawal may cause symptoms such as abdominal and muscle cramps, sweats, chills, nausea and vomiting. In rare cases it may cause death.

7. **In order to prevent loss of my pain medication, I will keep them in a safe place. If my pain medications or prescriptions are lost or stolen or otherwise not available to me, I understand that the prescription for pain medications will NOT be replaced without a police report.**

8. I will NOT give, sell, lend or in anyways provide my pain medications to any other person.

9. I understand that there will be NO early refills on my pain medications.

10. I understand that medication refill requests are only accepted 8:00-5:00 pm, Monday -Thursday and Friday 8:00 -12:00 pm. NO MEDICATIONS OR REFILL REQUESTS WILL BE TAKEN DURING NIGHTS, WEEKENDS OR HOLIDAYS. I also understand that it is my responsibility to anticipate the need for refills and make refill requests in a timely manner, allowing up to 3 business days.

11. I agree not to operate a vehicle, automobile, machinery or any potentially hazardous device while impaired by medications. I will not hold UHC or its employees responsible for any accidents, injuries, damages or loss, resulting from engaging in any of these activities while taking pain medications.

12. I understand that if I am pregnant, controlled substances may have adverse effects on the fetus. FOR FEMALE PATIENTS: I agree to notify UHC if I become or intend to become pregnant.

13. I agree to submit to unannounced drug testing to include urine, hair and blood tests. If drugs not prescribed for me, or excessive or low levels of drugs prescribed for me are found in any blood, hair or urine, all pain medications will be stopped, and I may be discharged from UHC. I also agree to submit to pill counts if requested .

14. If my pain is not controlled or my level of function with drug therapy does not improve to the satisfaction of my physician, I understand that pain medication may be discontinued, and alternative treatments will be used.

15. If my doctor recommends, I will see a specialist for addiction treatment, or other pain management.

16. I certify that I am not currently using illegal drugs or abusing prescription medication (s) and I am not undergoing treatment for substance dependence (addiction) or abuse.

17. **I agree to fill my medications only at the pharmacy listed below:**

Name: _____

Address: _____

Telephone Number: _____

I have read and understood all of the above terms. I have had the opportunity to ask questions about these terms of treatment and all of my questions have been answered to my satisfaction. I agree to abide by the terms and provisions in this agreement and understand that failure to do so may lead to termination of treatment.

SIGNATURE:

_____ _____

PATIENT: **DATE:**

Patient Name: _____ DOB: _____ Sex:____M ____F

PCP: _____ Allergies: _____

PAST MEDICAL HISTORY: (Mark all that Apply)

____ No Major Problems
____ Heart Disease:____ Heart Attack _____ Pace Maker _____ Chest Pain _____ Heart Failure
____ High Blood Pressure:
____ Arthritis: Type:_____
____ High Cholesterol
____ Lung Disease: ____ Asthma ____ Bronchitis ___ Pneumonia ____ COPD ___ Emphysema___ TB___
____ Thyroid Disease:____ Hypothyroid ____ Hyperthyroid ____ Other
____ Kidney Disease:____ Kidney Failure ____ Dialysis _____ Kidney Stones____ Other_____
____ GI Disease:____ Ulcers ____ Gastric Reflux _____ Gastritis_____ Hiatal Hernia____ Crohns Disease
____GU Disease:____ Recurrent UTIs _____ Prostatitis _____ Other
____ Diabetes: ____ Take Pills _____ Take Insulin _____ Diet controlled
____ Psychiatric Disorder: ____ Depression ____ Anxiety ____ Other
____Neurological Disorder:____ Epilepsy(seizures) ____ Polio ____ RSD ____ MS____ Cerebral Palsy
____ Blood Transfusions: When and Why? _____
____ Blood Diseases: ____ Anemia _____ Hepatitis type_____ HIV_____
____ Cancer: When and Where? _____
Other Major/Chronic Problems: _____

PAST SURGICAL HISTORY: _____ NONE (ONLY CHECK IF YOU HAVE NEVER HAD ANY SURGERY IN YOUR LIFE)
List
Date/Procedure:_____
_____
_____

SOCIAL HISTORY:
Smoking: ____ No ____ Yes, packs per day:_____ how long?_____
Alcohol use: ____ No ____ Yes How much? _____
Drug Abuse: ____ No ____ Yes Substances used? _____
Advance Directives/Living Will: ___ No ____ Yes ____ copy in our file
FAMILY HISTORY:_____ Unknown _____ None

Review of Systems: Are you currently having any of these problems

General: Fever Chills Fatigue Weight Loss Weight Gain Poor appetite

HEENT: Stuffy Runny nose Sore Throat Earache Nose bleeds Visual Changes

Cardiac: Chest pain Tightness Pressure

Pulmonary: Cough Shortness of Breathe Wheezing

GI: Nausea Heartburn Cramps Constipation Diarrhea Blood in stool

GU: Pain Increased Frequency Blood Odor

Neuro: Headache Numbness or tingling Shaking Loss of balance

Psychiatric: Anxiety Depression

Ortho: New joint pains

Skin: Rash Lesions
Endocrine: Hot flashes Diabetes Thyroid

_____ ___/___/___
SIGNATURE: DATE:

UNIVERSAL MEDICATION FORM

Todays Date: ______________________________

Name:	
Allergic To:	**Reaction:**
Allergic To:	**Reaction:**
Allergic To:	**Reaction:**
Allergic To:	**Reaction:**

List all Medicines you are currently taking: Prescription and Over the Counter

Date Prescribed:	Name of Medication:	Directions:	Prescribing Doctor:	Reason for Prescription: