Upstate Hand Center 1702 Skylyn Drive Spartanburg, SC 29307

Hand, Wrist, Elbow Evaluation

Name: **Age:**
Occupation:
Dominant Side: **Right** **Left**

What are you being evaluated for: _____
Have you previously had surgery on the affected arm? Yes or no
If yes, explain: _____
Where is your pain? (Diagram on last page)
Rate your pain: 0-10 (0=no pain, 10=worst pain in your life)
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? Circle all that apply
Are you involved in a law-suit in regards to this injury? Yes or no
Lawyer: _____
Are you filing 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
REST, BRACE, NDSAIDS (Ibuprofen, Aleve, Celebrex), Injections

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 and small?
Do you wake up with numbness or pain? Yes or no
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?
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 or 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 Diagram
Have you worn a brace for your wrist pain? Yes or no
Did 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 Diagram
Does your pain radiate? Yes or no
Where does it radiate: Circle all
Shoulder, hand
Have you had an injection into your elbow? Yes or no
Did the injection help? Yes or no
Can you straighten and bend your elbow without difficulty? Yes or no

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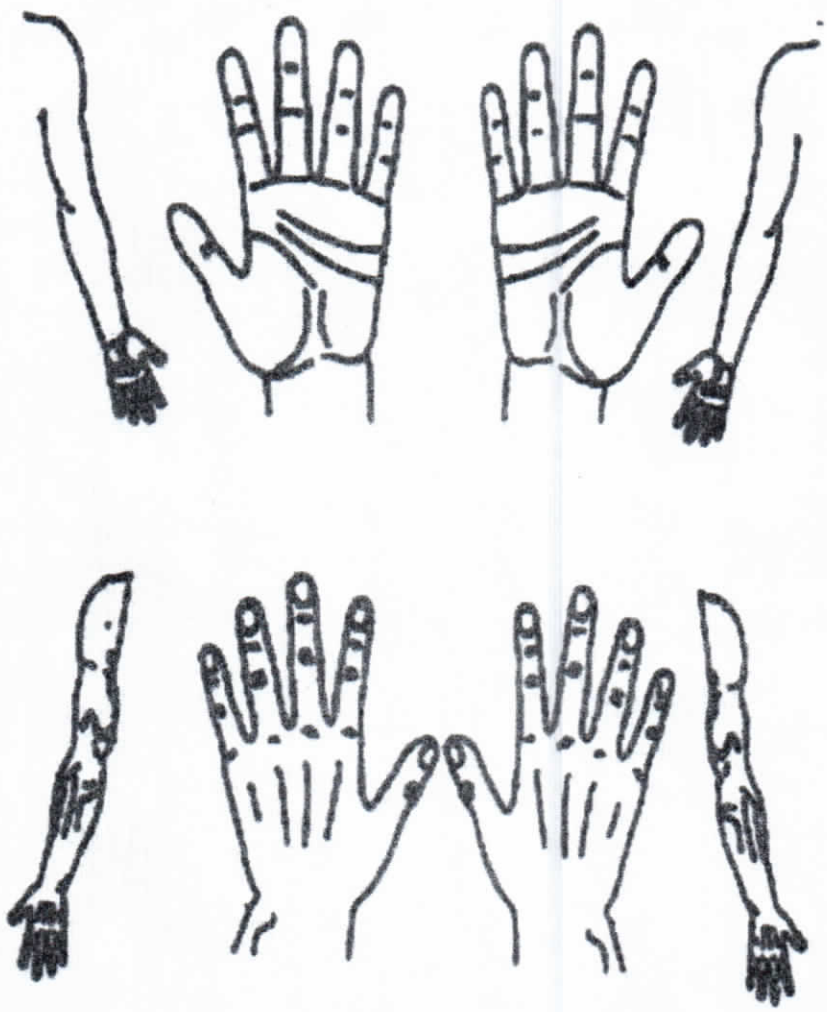
SHOULDER:

Does your shoulder 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
Do you have numbness in this arm? Yes or no
Does your neck hurt? Yes or no
Does your shoulder pain radiate? Yes or no
Where does it radiate: Neck, elbow, hand
Have you had steroid injections in your shoulder? Yes or no
When was your last injection? --/--/--
Have you had any physical therapy for your shoulder? Yes or no
Did it help? Yes or no
Have you had any special tests on your shoulder? Yes or no
What? MRI, CT Scan, EMG/NCS

DIAGRAM

LEFT HAND **RIGHT HAND**



Patient Name:_____ DOB:_____ Sex: __M __F

Primary Care Doctor:_____ Allergies: _____

PAST MEDICAL HISTORY : (Mark all that Apply)

___No Active 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: ____ Hypothryoid ____ Hyperthyroid ____ Other

___Kidney Disease: ____ Kidney Failure _____ Dialysis ___Kidney Stones ____ Other

___GI Disease: ___ Ulcers ____ Gastric Reflux ____ Gastritis ____ Hiatal Hernia ____ Crohns Disease

___GU Disease: ____ Recurrent Urinary Tract Infections _____ Prostatitis _____ Other

___Diabetes: ____ Take Pills ____ Take Insulin _____ Diet controlled

___Psychiatric Disorder:___Depression ____ Anxiety ____ Other

___Neurological Disorder: ____ Epilepsy (seizures) ____ Polio ____ RSD ____ Multiple Sclerosis ___ Cerebral Palsy

___Blood Transfusions: When and Why?_____

___Blood Diseases: _____ Anemia ____ Hepatitis: type_____ HIV_____

___Cancer: When and Where?_____

Other Major/Chronic Problems:_____

_____

Past Hospitalizations: _____ None

(List Date/Reason): _____

_____

Past Surgeries: _____ None

(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 __no copy in our file.

FAMILY HISTORY: _____ Unknown

_____

_____

Review of Systems: Are you currently having problems with you …

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:	Headaches		Numbness of tingling		Shaking	Loss of balance
Psychiatric:		Anxiety	Depression			
Ortho:	New joint pains					
Skin:	Rash	Lesion				
Endocrine:		Hot flashes	Diabetes	Thyroid		

_____ __/__/____

SIGNATURE **DATE**

Patient Information Sheet

Last Name: _____ First Name: _____ MI: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home #: _____ Work #: _____

Cell #: _____ Fax #: _____

DOB (MM/DD/YY): _____ SS #: _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Emergency Contact Information:

Name: _____

Home #: _____ Cell #: _____

Patient Employment Information: ☐ Full Time ☐ Part Time ☐ Student

Employer Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

RESPONSIBLE PARTY INFORMATION:

Billing Information: ☐ **Same As Patient or** ☐ **If different please fill out the following information.**

Last Name: _____ First Name: _____ MI: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home #: _____ Work #: _____

Cell #: _____ Fax #: _____

Other #: _____

DOB (MM/DD/YY): _____ Sex: ☐ Male ☐ Female SS #: _____

Relationship to Patient: _____

Responsible Party Employment Information: ☐ Full Time ☐ Part Time ☐ Student

Employer Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Patient's or Authorized Person's Signature:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or other medical benefits to t assigned to DR. SONYA CLARK (Physician Name) for procedures and/or services render.

_____ _____

Authorized Signature Date

_____

Relationship to Patient

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION

I hereby authorize you to release any information, including diagnosis, labs and records of any treatment or examination rendered to me or my child, during the period of such care, to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay insurance benefits, otherwise payable to me directly, to the physician. I understand that my carrier may pay less than the actual amount charged by the provider and may not pay for non covered services. I agree to be responsible and pay those described unpaid fees on my behalf or my dependents. Should I not pay these amounts in full and my account is turned over to an outside agency for collection, I understand I will be responsible for all cost of collections and attorney fees.

Signature of Patient/Guarantor:_____ Date:_____

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, _____, _____, _____, _____, _____.

Signature:_____ Date:_____

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 corrections 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 about it 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 you access your information.

By your signature below, you acknowledge receipt of this Notice of Privacy Practices.

Signature:_____ Date:_____

UNIVERSAL MEDICATION FORM

Todays Date:_____

Patients Name:	
Patients Date of Birth:	
Phone Number:	
Allergic To:	**Reaction:**
Allergic To:	**Reaction:**
Allergic To:	**Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over the counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko).

Include all medications taken as needed (example: nitroglycerin).

Date prescribed	Name of Medication/Dosage	Directions/How often taken	Prescribing Doctor	Reason for Prescription

UPSTATE HAND CENTER

Patient Name: _____ **Account Number:** _____

FINANCIAL POLICY OF UPSTATE HAND CENTER

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE 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 collections prior to your office visit. If you are unable to pay your balance in full, contact the office (864) 308-8668 to discuss with our billing department.
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 time of service. If you can't pay in full, contact our billing department prior to seeing the doctor to make payment arrangements.
7. No show for missed appointment. When an appointment is schedules with the doctor, time is specially allocated for you. Unable to keep an appointment, we ask the courtesy of a phone call to cancel your appointment. We prefer a 24 hour notice of cancellation. Failure of no show to appointment will cost you $50.00.

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 our billing department 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
Spartanburg, SC 29307
(864) 308-8668

Pain Management Agreement

I voluntarily request that my physician treat my painful condition. 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 or I will notify UHC staff know that I am under a separate pain management and will not receive narcotics from this practice.
3. I will receive controlled substances only from 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 they consult with UHC before prescribing any medications that might after mood or consciousness.
4. I agree to keep 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 (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory 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 result in death.
7. Any changes in my pain pattern that cause me to request a change in pain medications must be addressed at a scheduled office visit.
8. I understand that I may NOT increase, decrease, stop, or alter my dose or use of pain medications without prior approval from UHC. Approval will not be given after the fact.
9. **In order to prevent loss of my pain medications, I will keep them in a safe place. If my pain medications are lost or stolen or otherwise not available to me, I understand that the prescriptions for pain medications will NOT be replaced.**
10. I will NOT give, sell, lend, or in anyways provide my pain medication to any other person.
11. I understand that there will be NO early refills of my pain medications.
12. I understand that medication refill requests are only accepted 8:00 a.m.- 5:00 a.m., Monday-Thursday and Friday 8:00 a.m.-12:00 p.m. 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 four (4) business days.

13. I understand that some pain medications can cause a decrease in mental function. 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 activities while taking pain medications.
14. I understand that if I am pregnant, controlled substances may have adverse effects on the fetus, and that there is a strong likelihood that any baby born to a woman taking controlled substances will be physically dependent and could suffer withdrawal symptoms. FOR FEMALE PATIENTS: I agree to notify UHC if I become, or intend to become, pregnant. If I have not been sterilized or am not postmenopausal, I agree to take reasonable and prudent precautions to ensure that I will not become pregnant while taking these medications.
15. I hereby give my physical permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s).
16. **I agree to submit to unannounced, observed drug testing including urine, hair and blood tests. If drugs not prescribed for me, excessive or low levels or drugs prescribed for me are found in my blood, hair or urine, all pain medications may be stopped and I may be discharged from UHC. I also agree to submit to pill counts if requested by UHC.**
17. If my pain is not controlled or my level of functioning with drug therapy does not improve to the satisfaction of my physician, I understand that the pain medications may be discontinued and alternate treatments will be used.
18. If my doctor recommends I will see a specialist for addiction treatment, or other pain management.
19. 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.
20. 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 and treatment and all of my questions have been answered to my satisfaction. I agree to abide by the terms and provisions of this agreement and understand that failure to do so may lead to termination of treatment.

SIGNATURES:

_____ _____
PATIENT DATE

_____ _____
PROVIDER DATE