Patient Information

Confidential Information: The information herein will not be released except when you have authorized us to do so. This information will be used by Dr. Cole and the Boise Plastic Surgery Boise Hand Center office staff to plan and coordinate your medical care. Thank you.

Today's Date: _____/_____/_____

Patient's Legal Name: _____

Preferred Name: _____

Date of Birth: _____/_____/_____ Sex: Male / Female

Height: _____ ft _____ in Weight: _____ lbs

SS#: _____ - _____ - _____

Contact Information:

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

Email Address: _____

If minor, Parent/Guardian Name: _____ Relationship: _____

Do we have permission to contact you by email? YES / NO Reminder text? YES / NO

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

What brings you to our office today? _____

Is this a Workers Compensation Case? YES / NO

If yes, Date of Injury: _____/_____/_____

Claim #: _____

Workers Compensation Company name: _____

Case Coordinator name: _____

Contact information: _____

Primary Insurance Information:

Medical Insurance Company: _____

Name of Policyholder: _____

Member/Policy Number: _____ Group Number: _____

Secondary Insurance Information:

Medical Insurance Company: _____

Name of Policyholder: _____

Member/Policy Number: _____ Group Number: _____

Please provide your insurance card and photo ID to the front desk staff. We will make a copy and return it to you promptly. Thank you

Health Information:

Allergies to medications, drugs, or anesthesia: (known or suspected)

_____

_____

If yes, please explain:

_____

_____

Current Medications/Supplements:

Please list ***ALL*** medications and supplements you are currently taking.

(including over the counter and non-prescription medications):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical History:

Are you currently under the care of, or have you ever been under the care of, a psychiatrist, psychologist, or mental health counselor? YES / NO

If yes, please explain: _____

Do you have, or have you ever had, drug addiction or dependency issues? YES / NO

If yes, please explain: _____

Do you currently smoke? YES / NO If yes, how many per day? _____

Do you drink alcohol? YES / NO If yes, how much and how often? _____

Are you pregnant? YES / NO If yes, estimated due date: _____

Do you have, or have you ever had, any of the following conditions?

	YES	NO		YES	NO
AIDS or HIV positive	☐	☐	Cancer	☐	☐
Hepatitis	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Chest Pains	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐
Arthritis	☐	☐	Colitis	☐	☐
Irregular Heart Beat	☐	☐	Shortness of Breath	☐	☐
Asthma	☐	☐	Diabetes	☐	☐
Kidney Problems	☐	☐	Skin Cancer	☐	☐
Back Problems	☐	☐	Ear/Eye Problems	☐	☐
Migraine Headaches	☐	☐	Stomach Problems	☐	☐
Blood Clots in legs	☐	☐	Stroke	☐	☐
Blood Disorders	☐	☐	Heart Problems	☐	☐
Nose/Throat Problems	☐	☐	Thyroid Problems	☐	☐
Bleeding Problems	☐	☐	Heart Murmur	☐	☐
Pneumonia	☐	☐	Tuberculosis	☐	☐
Breathing Problems	☐	☐	Heart Palpitations	☐	☐
Psychiatric Condition	☐	☐	Transfusion	☐	☐

If you answered yes to any of the above, please explain: _____

_____

_____

Past Hospitalizations or Surgical Procedures including dates: _____

_____

_____

Is there any other medical information you would like Dr. Cole to know about? _____

_____

Please sign below. I certify the above information to be true to the best of my knowledge.

_____ _____

Patient (or legal guardian) Date

CONSENT AND CONDITIONS OF TREATMENT

Patient Name: _____ ("Patient") Birth Date: ___/___/___

CONSENT FOR TREATMENT. I voluntarily consent to care and treatment of the Patient by Boise Plastic Surgery Boise Hand Center, PLLC ("PRACTICE") and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. If PRACTICE personnel suffer a needle stick or are exposed to blood or body fluids, I consent to the testing of Patient for any blood-borne disease for the protection of PRACTICE personnel.

CONDITIONS FOR TREATMENT AT PRACTICE. In consideration for the care and treatment that Patient will receive or has received at PRACTICE, I agree to the following:

1. **Payment.** I agree that I am responsible for any co-payments, deductibles or other charges for services to Patient that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and PRACTICE. I agree to make such payments according to PRACTICE's regular terms of payment. Where appropriate, I agree to submit and cooperate with PRACTICE in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties. I understand that I will remain responsible for any amount not paid by insurance or a third party. If the Patient's account becomes delinquent, I agree to pay interest and fees according to PRACTICE's policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys' fees, and court costs. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient.

2. **Assignment and Authorization.** I hereby assign and authorize direct payment to PRACTICE of any payments or other benefits to which I or the Patient may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with Patient's care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full. To the extent such authorization is required by applicable regulations, I hereby authorize Practice or any other holder of medical information about the Patient to release such information to the Centers for Medicare and Medicaid Services and its agents as necessary to determine benefits payable for services provided to Patient. This authorization shall not modify or limit Practice's right to use or disclose protected health information as otherwise allowed by applicable law or Practice's Notice of Privacy Practices.

3. **Billing Practices.** I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. PRACTICE may amend such quotes and I will be responsible for charges for services actually rendered. I understand and agree that PRACTICE will require payment of all accounts at the time the services are rendered unless PRACTICE has expressly agreed to contrary arrangements. Where insurance is available, PRACTICE will bill and allow a reasonable time for the insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, the Patient and I will be billed for all charges and interest. Payment is due upon receipt of the bill.

NO GUARANTEE. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of Patient's care or treatment at PRACTICE.

PERSONS FOR WHOM PRACTICE IS NOT LIABLE. I understand that PRACTICE is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by PRACTICE may be involved in my care or treatment, including but not limited to other practitioners, laboratories, diagnostic testing facilities, contractors, vendors, product technicians, etc. I understand that PRACTICE is not liable for the acts or omissions of non-employees or PRACTICE employees acting outside the course and scope of their duties.

INJURY CAUSED BY THIRD PARTY. Please indicate the following:
[ ] My condition was not caused by the wrongful act or omission of another person.
[ ] My condition was caused by the wrongful actions of the following person[s]:
Name: _____
Address: _____
_____

NOTICE OF PRIVACY PRACTICES. I have received a copy of PRACTICE's Notice of Privacy Practices on this or a prior occasion. [Please Initial]: _____

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative, and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

_____ _____
(Print Name) (Date)

_____
(Signature)

_____
Relationship to Patient/Authority

BOISE PLASTIC SURGERY
BOISE HAND CENTER