Sound Hand and Orthopedics, PLLC
Seattle Clinic- 901 Boren Ave., Ste. 900, Seattle, WA 98104
Factoria Swedish- 12917 SE 38th St., Ste. 100, Bellevue, WA 98006
Bellevue Clinic- 1200 112th Ave NE Ste. B2350, Bellevue, WA 98004

Phone-206.257.3350 / Fax-206.257.3352 - support@soundhandortho.com

Patient Registration Form

Today's Date: _____Primary Care Provider: _____

Patient's last name: _____First_____M.I._____

Date of Birth: _____Age: _____Sex_____

Mailing address: _____

City: _____State: _____Zip code: _____

Cell phone: _____ Home: _____

Work:_____ E-mail: _____

Who can we thank for this referral? _____

☐ER ☐Health practitioner ☐Family/Friend ☐Insurance ☐Internet ☐L&I ☐Called hospital

☐Other_____

Insurance Information

Medical Insurance [ ] Workman's Comp [ ] Auto Insurance [ ] Self Pay [ ]
If this is medical insurance and you are the subscriber, no need to complete information below.

Relationship to primary holder: Spouse: _____Child: _____Other: _____ (please check one)

Subscribers name: _____ Date of Birth: _____

Workman's Comp or Auto Claim

Claim #_____Date of Injury: _____Company: _____

Manager or Adjusters name: _____Phone #: _____

Address: _____City: _____State: _____Zip: _____

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 money owed. I also authorize Sound Hand and Orthopedics, PLLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature_____ Date: _____

Sound Hand and Orthopedics, PLLC

Authorization to Leave Personal Health Information
By Alternate Means

Patient Name: _____ DOB: _____

Please check all that apply:

- ☐ May leave detailed message on voicemail at home #: _____
- ☐ May leave detailed message on voicemail at work #: _____
- ☐ May leave detailed message on cell phone #: _____
- ☐ May leave information with Spouse (name): _____
- ☐ May leave information with other family member (name): _____
- ☐ May leave detailed message at a different #: _____
- ☐ May leave information on e-mail account: _____
- ☐ May leave information with interpreter: _____

In Case of Emergency

Name of friend or family member: _____

Phone #: _____

With this signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____ _____
Signature of Patient Date

_____
Patient Name

Sound Hand and Orthopedics, PLLC

We want to make sure that all of our patients get the best care possible. We are required to request your racial and ethnic background so that we can periodically review our patient data and make sure that everyone is receiving the highest quality of care.

Patient/Guardian Signature: _____ Date:_____

Patient Name: _____

Marital Status:
☐Married
☐Single
☐Divorced
☐Widowed
☐Legally separated
☐Unknown

Employment Status:
☐Employed full-time
☐Employed part-time
☐Not employed
☐Self employed
☐Retired
☐On active military duty
☐Unknown

Student Status:
☐Not a student
☐Full-time student
☐Part-time student

Residence Type:
☐Private Home
☐Nursing Home
☐Residential Treatment
☐Skilled Nursing Home

Do you consider yourself Hispanic/ Latino?
Yes:☐ No:☐ Decline:☐

Language:
☐English
☐Spanish
☐Other
☐Decline

Which category best describes your race?
☐American Indian or Eskimo or Aleut
☐ Asian or Native Hawaiian or Pacific Islander
☐Black or African American
☐White
☐Other
☐Decline

Sound Hand and Orthopedics, PLLC

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare information
We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting protected Health Information
We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights
You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

901 Boren Ave., Suite 800, Seattle, WA 98104
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Sound Hand and Orthopedics, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form does not constitute legal advice and covers federal, not state laws.

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of South Hand and Orthopedics. The Statement of Privacy Practices describes the types of use and disclosures of my protected health information that might occur in my treatment, payment of services or in the performance of office healthcare operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices can also be provided upon request.

South Hand and Orthopedics reserves the right to change the privacy practices that are described in the statement of privacy practices. If privacy practices change, I will be offered a copy of the revised statement of privacy practices at the time of my first visit after the revisions become effected. I may also obtain a revised statement of privacy practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORTY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the persons indicated below.

Any member of my immediate family	[ ] YES [ ] NO
Spouse Only	[ ] YES [ ] NO
Other (Please specify)	[ ] YES [ ] NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

FOR OFFICE USE ONLY:

Provided to patient prior to treatment [ ] YES [ ] NO Date statement provided: _____

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

_____ The patient refused to sign

_____ Patient needed more time to review Statement of Privacy Practices

_____ Patient wanted to consult with another person before signing statement

_____ Due to an emergency situation, it was not possible to obtain an acknowledgment

_____ We were unable to communicate with the patient

_____ Other (please specify below)

Employee signature: _____ Date: _____

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Sound Hand and Orthopedics, PLLC

Credit Policy

Thank you for selecting Sound Hand and Orthopedics for your health care needs. In order to effectively bill and collect on charges incurred at our practice, we require all patients to read and sign this credit policy. By signing this document, you agree to adhere to the policies detailed herein. The purpose of these guidelines is to clarify standards and expectations for both the office and our patients. Thank you for your cooperation.

Patient Responsibility: As a courtesy, Sound Hand and Orthopedics will bill on behalf of our patients to all healthcare plans with which we are contracted; however, it is the responsibility of the patient and/or guarantor to verify whether or not Rajiv Goel M.D. is contracted under their individual plan and to be aware of the specific benefit exclusions or limitations of said plan. Please contact your Member Services Department for clarification on coverage. In addition to this credit policy, Sound Hand and Orthopedics may require patients to sign additional waivers/disclaimers stating that you assume financial responsibility for services rendered at your request.

Payment Responsibility: For each visit, patient and/or guarantor are required to bring photo identification, their current insurance card(s), and applicable co-payment. Due to rapidly changing coverage and identification numbers, as well as to ensure correct billing, **a current insurance card is required to be presented at each visit.** Co-pays and deductibles are due and payable at time of service unless arrangements have been made with our business office.

Patients who are self-pay will receive a discount on clinic charges if their visit is paid in full at the time of service. Patient and/or guarantor assume responsibility for all charges and unpaid balances resulting from treatment provided by Sound Hand and Orthopedics. Payment for service(s) is due within 30 days of the first statement. If you are unable to pay the balance in full within 30 days, please contact our business office to make payment arrangements.

Insurance reimbursement is a contract between you and your carrier. If payment has not been received after 60 days from the time of service, please contact your carrier to check on the status of your claim and immediately contact the business office if matters are not in order. Delinquent accounts more than 60 days past due with no payments and/or defaulted payment arrangements are subject to review and possible collection action. A $30.00 fee will be charged if your check is returned from your bank unpaid.

Appointments: Patients who are unable to keep their appointment should call at least 24 hours in advance to notify scheduling. Patients who consistently fail to provide 24 hour cancellation notice and/or do not show up for scheduled appointments with Sound Hand and Orthopedics will be charged a fee of $50.00 or more per missed appointment and may be dismissed from the practice.

It is not our intention to cause undue hardship; however we must collect our receivables as efficiently as possible in order to continue our service to the community.

I have read, and accept the credit policy terms outlined above. I understand that I am ultimately financially responsible for payment of my account with Sound Hand and Orthopedics. I agree that in the event additional costs and/or fees are incurred in connection with the collection of my account, I understand that I am responsible for such charges.

_____ _____

Patient Name Printed Date of Birth

_____ _____

Patient/ Guarantor Signature Date

Address: _____ City: _____ State: _____ Zip _____

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Sound Hand and Orthopedics, PLLC

Dr. Goel
Chief Complaint & History of Present Illness

Patient Information: **Today's Date:** _____

Name: _____ DOB: _____ Age: _____

Handed: ☐ R ☐ L ☐ Ambidextrous

Sex: ☐ Male ☐ Female Work Status: ☐ Unemployed ☐ Disabled ☐ Sick Leave ☐ Retired

Occupation: _____

Hobbies/ Sports: _____

☐ Litigation ☐ Auto Ins. ☐ L&I Claim # _____

Primary Care: _____ ☐ MD ☐ DO ☐ NP ☐ PA ☐ DC ☐ ND

Referral: _____ ☐ ER ☐ MD/DO/DC/ND ☐ NP/PA ☐ PT/OT
☐ Case worker ☐ Attorney

Chief Complaint:

Present Problem: _____

_____

History of Present Illness:

Location: Where is your pain? _____ ☐ R ☐ L ☐ Both

Duration: Date of Injury: _____ Date of Onset: _____
☐ Gradual ☐ Sudden
Previous Episodes: _____

Mechanism: ☐ Injury (Describe) _____
☐ No Injury. What do you think may have caused your symptoms? _____
☐ Job related ☐ Sports related ☐ MVA

Quality: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Burning ☐ Tingling ☐ Other _____

Severity: On a scale of 0-10, how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

Associated Symptoms: ☐ Swelling ☐ Bruising ☐ Numbness ☐ Locking/ Catching ☐ Other _____
☐ Radiating (spreading) _____

Timing: ☐ Constant ☐ Intermittent (Comes and goes) ☐ Wakes from sleep

Context: Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

Modifying: What makes your symptoms better? _____
☐ Rest ☐ Ice ☐ Heat ☐ Elevation ☐ Shaking the hand out
What makes your symptoms worse? _____
☐ Lifting ☐ Pinching ☐ Holding phone ☐ Lying down ☐ Turning key
☐ Standing ☐ Squatting ☐ Stairs ☐ Getting out of a chair ☐ Open jars

Previous Studies: ☐ X-Rays ☐ MRI ☐ CT ☐ Bone Scan ☐EMG/ Nerve Study
When: _____ Facility: _____

Previous Treatments: ☐ Medication ☐ Injection ☐ PT/OT ☐ Splints ☐ Surgery Please describe below:

_____

_____

Did the treatment help? ☐ Yes ☐ No Explain: _____

_____

Sound Hand and Orthopedics, PLLC

Dr. Goel
Medical History

Date:_____

Patient Information:

Name: _____ DOB: _____ Age: _____

Check all that apply:

Musculoskeletal:
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Gout/ Crystal disease
☐ Osteoporosis
☐ Tendonitis/ Bursitis
☐ Fibromyalgia
☐ Fracture: _____
☐ Other: _____

Cardiovascular:
☐ Hypertension
☐ High Cholesterol
☐ Coronary Artery Disease
☐ MI (Heart Attack)/Angina
☐ Congestive Heart Failure
☐ Arrhythmia
☐ Blood Clot/ DVT/ PE
☐ Peripheral Vascular Disease
☐ Leg Edema
☐ Varicosities
☐ Other: _____

OB/ Gyn:
☐ Post Menopause – HRT
☐ Amenorrhea
☐ Breast Cancer – Node Dissection
☐ Previous Lymphedema
☐ Other: _____

Eyes, Ears, Nose & Throat
☐ Glaucoma
☐ Blind
☐ Deaf
☐ Hearing Aids
☐ Chronic Sinus Infections
☐ Difficulty Swallowing
☐ Difficulty with Previous Intubation
☐ Other: _____

Neurologic:
☐ Neuropathy
☐ CVA (Stroke)
☐ Dementia
☐ Seizures
☐ Parkinson's
☐ Multiple Sclerosis
☐ RSD
☐ Other: _____

Pulmonary:
☐ Emphysema

☐ Asthma
☐ COPD
☐ Bronchitis
☐ Other: _____

Endocrine:
☐ Diabetes (insulin?)
☐ Thyroid (hypo/hyper)
☐ Other: _____

Renal:
☐ Urinary Tract Infections
☐ Kidney Stones
☐ Kidney Failure/ Dialysis
☐ Other: _____

Dental:
☐ Tooth Decay
☐ Loose Teeth
☐ Dentures
☐ Gum Disease
☐ Other: _____

Gastrointestinal:
☐ GERD
☐ Ulcer/ GI Bleed
☐ Hepatitis
☐ Pancreatitis
☐ Crohn's/ IBS
☐ Gallstones
☐ NSAID Intolerance
☐ Other: _____

Psychiatric:
☐ Depression

☐ Substance Abuse
☐ PTSD
☐ Anxiety
☐ Memory Loss
☐ Other: _____

Skin:
☐ Chronic Sores/ Ulcers
☐ Psoriasis
☐ Other: _____

Hematologic/ Lymphatic:
☐ HIV/AIDS
☐ Clotting Problems
☐ Bleeding Problems
☐ Other: _____

Chronic Infections:
☐ MRSA
☐ Other: _____

Sound Hand and Orthopedics, PLLC

Surgical History

Surgery	Year	Surgery	Year
☐ Removal: Gallbladder	_____	☐ Coronary Artery Bypass	_____
☐ Removal: Appendix	_____	☐ Heart Valve Repair	_____
☐ Removal: Tonsils	_____	☐ Carotid Endarterectomy	_____
☐ Hernia Repair	_____	☐ Vascular Stent/ Bypass	_____
☐ Hysterectomy	_____	☐ Other: _____	_____

Bone/ Joint Surgeries	Year
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____

Medications

Medication	Dose	Frequency
☐ Aspirin / Plavix / Coumadin (circle one)	_____	_____
☐ HTN (please specify)_____	_____	_____
☐ Insulin _____	_____	_____
☐ Oral Diabetes _____	_____	_____
☐ _____	_____	_____
☐ _____	_____	_____
☐ _____	_____	_____
☐ _____	_____	_____
☐ _____	_____	_____

Allergies

☐ No Known Drug Allergies (please specify reaction: eg itch/ hives/ throat swelling)

☐ Penicillin _____ ☐ Aspirin_____ ☐ Adhesives_____ ☐Latex

☐ Sulfa _____ ☐ Anesthetics_____ ☐ Other: _____

Social History

Do/ did you smoke?	☐ Yes ☐ No	Packs/day? _____
Do/ did you drink alcohol?	☐ Yes ☐ No	Drinks/day? _____
Do / did you use drugs?	☐ Yes ☐ No	Describe: _____
Are you Pregnant	☐ Yes ☐ No	If Yes, # of Months: _____

Family History

☐ Arthritis	☐ Coagulation Defects	☐ Diabetes Mellitus
☐ Hypertension	☐ Heart Disease	☐ CVA/ Stroke
☐ Osteoporosis	☐ Depression/ Mental Illness	☐ Drug or Alcohol Addiction

☐ Cancer – List all Types: _____

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Sound Hand and Orthopedics, PLLC

Dr. Goel
Review of Systems

Patient Information:

Name: _____ DOB: _____ Age: _____

Allergies: _____ Height: _____ Weight _____

Have you had problems in any of the following areas in the last twelve months or since your last visit which were not listed in your medical problems? Please check all that apply and explain in space provided.

Musculoskeletal:
☐ Joint Pain Where:_____
☐ Muscle weakness/ aches
☐ Back Pain: Low/Mid/ Upper
☐ Swollen joints Which:_____
☐ Stiffness Where:_____
☐ History of Fall When: _____
☐ Use cane/ walker/ brace
☐ Fracture Which bone: _____

Neurologic:
☐ Headaches
☐ Dizziness
☐ Seizures
☐ Tremor
☐ Weakness
☐ Numbness

Respiratory:
☐ Chronic Cough
☐ Productive Cough
☐ Shortness of Breath

Cardiovascular:
☐ Chest Pain
☐ Palpitations
☐ Leg Pain on Exertion
☐ Racing Heart Beat
☐ Loss of Stamina

Genitourinary:
☐ Painful Urination
☐ Difficulty with Urination
☐ Blood in Urine
☐ Urgency
☐ Incontinence

Gastrointestinal:
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Blood in Stool
☐ NSAID Intolerance

Skin:
☐ Frequent Rashes
☐ Ulcers
☐ Burning Pain
☐ Dryness
☐ Change in Hair/ Nails

Endocrine:
☐ Heat or Cold Intolerance
☐ Excessive Sweating
☐ Excessive Urination
☐ Excessive Thirst

Psychiatric:
☐ Drug Dependency
☐ Alcohol Dependency
☐ Depressed Mood
☐ Sleep Alteration

Ears, Nose and Throat:
☐ Hearing Loss
☐ Hoarseness
☐Trouble Swallowing
☐ Ringing in Ears

Constitutional:
☐ Weight Loss
☐ Frequent Fever
☐ Loss of Appetite

Eyes:
☐ Blurred Vision
☐ Double Vision
☐ Vision Loss

Hematologic/ Lymphatic:
☐ Easy Bleeding
☐ Easy Bruising
☐ Blood Clots
☐ HIV/ AIDS
☐ Transfusions

Dental:
☐ Tooth Decay
☐ Loose Teeth
☐ Gum Disease
☐ Pain in Teeth or Gums

Other:
☐ _____
☐ _____
☐ _____
☐ _____

☐ **I have not had any problem in the above mentioned areas in the last 12 months.**
☐ **I have not had any new problems or changes in the above mentioned areas since my last visit.**
☐ **I have discussed the above symptoms with my primary care physician.**

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Phone: 206-257-3350 **Fax: 206-257-3352**