**Katy Hand & General Surgery, P.A.**

**Faranak Vossoughi, M.D.**

19255 Park Row Suite 202

Houston, TX 77084

281-693-HAND (4263)

**New Patient information Form**

 Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Marital Status: ⁭Single ⁭Married ⁭Divorced ⁭Widow -Race \_\_\_\_\_\_-Ethnicity\_\_\_\_\_\_\_\_\_

How did you hear about Dr. Faranak Vossoughi? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Languages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Doctor or Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe the problem that brings you here today:**

**History of present illness** affected side: ⁭ Left ⁭ Right ⁭Both Date of onset\_\_\_\_\_\_\_\_\_\_\_\_\_ Pain 1-10\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Did you have an injury? ⁭ Yes ⁭ No At work ⁭ MVA⁭ other\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_ How\_\_\_\_\_\_\_\_\_\_\_\_\_
* What type of injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have pain? ⁭Yes ⁭ No
* Where is your pain? ⁭ R ⁭ L Digits Thumb= Thumb ⁭ Index ⁭ Middle ⁭ Ring ⁭Small ⁭Hand ⁭Wrist ⁭ Forearm ⁭Elbow ⁭ Upper Arm ⁭Shoulder ⁭ Neck Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How long have you had pain? Day\_\_\_\_\_\_ Weeks\_\_\_\_\_\_ Months\_\_\_\_\_\_ Years\_\_\_\_\_\_
* How severe is your pain? ⁭ None 0 ⁭Negligible 1-2 ⁭Mild 3-4 ⁭Moderate 5-6 ⁭Severe 7-8 ⁭Unbearable 9-10
* Is your pain Intermittent/ Constant? Intermittent ⁭ Constant
* What type of pain is it? Dull ⁭ Burning ⁭ Sharp Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When is the pain worse? All the time ⁭ Night ⁭ Morning Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What aggravates your pain? Using Hand ⁭ Typing ⁭Driving Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What relieves your pain? Nothing ⁭ Certain positions ⁭ Rest Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Any other Symptoms? None ⁭ Numbness ⁭Tingling ⁭ Night ⁭AM ⁭ Radiation ⁭Dropping objects Other\_\_\_\_\_\_\_\_
* Are you : Left Handed\_\_\_\_\_\_\_\_\_ Right Handed\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

1. Do you have any major medical problems? ⁭ None ⁭Anxiety ⁭Arthritis ⁭Asthma ⁭Cancer ⁭Depression ⁭Hypertension ⁭Hepatitis A B C ⁭HIV ⁭Hyperthyroidism ⁭Hypothyroidism ⁭Hemodialysis ⁭Kidney failure ⁭Liver disease ⁭Obesity ⁭Osteoporosis ⁭Stroke ⁭Sickle cell disease Heart attack Sleep apnea Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you suffered any injuries in the past? Yes/No **(if yes list and date)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you had any hospitalizations? Yes/No **(if yes list and date)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently taking any medication? Yes/No **(if yes list them)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you allergic to any medications**?** Yes/No **(if yes list them)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any surgical history? Yes/No **(if yes list and date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History**

1. Any inherited diseases in your family? ⁭No ⁭Yes
2. Immediate family members (parents, children, siblings) have had the following:

Mom: Alive: Yes or No Diabetes ⁭Hypertension ⁭Stroke ⁭Gout ⁭Heart attack ⁭Cancer ⁭HIV ⁭Hepatitis ⁭Arthritis ⁭Rheumatoid ⁭Kidney Disorder Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dad: Alive: Yes or No ⁭Diabetes ⁭Hypertension ⁭Stroke ⁭Gout ⁭Heart attack ⁭Cancer ⁭HIV ⁭Hepatitis ⁭Arthritis ⁭Rheumatoid ⁭Kidney Disorder Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_ ⁭Diabetes ⁭Hypertension ⁭Stroke ⁭Gout ⁭Heart attack ⁭Cancer ⁭HIV ⁭Hepatitis ⁭Arthritis ⁭Rheumatoid ⁭Kidney Disorder Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

1. Employment: ⁭ None ⁭ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⁭Disabled ⁭ Student
2. Are you married? ⁭Yes ⁭ No Other Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Children? ⁭Yes ⁭No #
3. How often do you drink? ⁭ None ⁭ Social ⁭ Moderate ⁭ Heavy
4. How often do you smoke? ⁭ None ⁭Occasional ⁭ Moderate ⁭ Heavy Quit smoking?, how long ago?\_\_\_\_\_\_\_\_
5. Do you use illicit drugs? ⁭Yes ⁭No
6. Hobbies, contacts or extreme sports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems: Abnormalities are circle (√)**

⁭Obesity ⁭Weight Weight loss ⁭Dermatitis ⁭Psoriasis ⁭VHD ⁭HBP ⁭Asthma ⁭Emphysema ⁭Colitis ⁭Acid Reflux ⁭Infection ⁭Prostate ⁭Renal Failure ⁭RA ⁭SLE ⁭Gout ⁭ frequent infection ⁭Seasonal ⁭Hyperthermia ⁭Drug Reactions ⁭Seizures ⁭Stroke ⁭Depression ⁭Anxiety ⁭Diabetes ⁭Hypothyroidism ⁭Bleeding disorder⁭ Anemia ⁭Cancer ⁭ Osteoporosis Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Katy Hand & General Surgery, P.A.**

**Faranak Vossoughi, M.D.**

19255 Park Row Suite 202

Houston TX 77084

281-693-HAND (4263)

1. **Authorization to Release Medical records to my insurance Company for payment of Dr. Faranak Vossoughi medical fee.**

I authorize Dr. Faranak Vossoughi, M.D to release (disclose) all or part of my records necessary to ensure payment on any claim, to hospital or medical service companies, insurance carriers, welfare funds, patient’s employer and/or any third party payer.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Signature Print Name Date

1. **Medicare Release For Medicare Patients Only.**

I am giving Dr. Faranak Vossoughi, permission to ask Medicare for payments for my medical care. I authorize her to release to the center of Medicare Services and/or any third party payer and/or its agents, intermediaries or carriers any information needed to determine Medicare benefits or the benefits payable for related services. I request that payment of authorized benefits be made on my behalf to Katy Hand & general Surgery, for any services furnished by Dr. Vossoughi. I authorize Dr. Vossoughi to release to the Center for Medicare Services information needed to determine these benefits or the benefits payable for related services. I also understand that Dr. Vossoughi will be submitting a claim for payment on my behalf.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Signature Print Name Date

1. **Acknowledgement of receipt of notice of Patient Privacy from Dr. Faranak Vossoughi**

By my signature below, I hereby acknowledge receipt of Notice of Privacy Practices, and I acknowledge that the Dr. Faranak Vossoughi will use and disclose my health information for purpose of treating me, obtaining payment for services rendered to me, and conducting health care operating.

I have been advised of my rights to obtain access to and control my Protected Health information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Signature Print Name Date

1. **I understand that I am responsible for any payment not covered by Medicare, my insurance company or worker’s compensation insurance company and will provide payment upon request.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Signature Print Name Date

**Katy Hand & General Surgery, P.A.**

**Faranak Vossoughi, M.D.**

19255 Park Row Suite 202

Houston TX 77084

281-693-HAND (4263)

Fax: 281-693-4265

**AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Dr. Faranak Vossoughi/ Katy Hand & Surgery, to use and disclose the protected health information described below for the following purpose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 This use or disclosure will be made by the office staff of this practice.

The health information to be used and/or disclosed is specifically described as follow:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The person or class of person to whom the information will be disclosed or who use the information is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The practice is hereby authorize to make the disclosure to these classes of persons and the aforementioned classes of persons are hereby authorized to use or disclosed the information.

This authorization shall be in force and effective until the following event and/ or date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the following person at the practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

at the following address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its action. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected be Federal HIPPA privacy regulations.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Personal Reperesentative Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Patient or Personal Representative Description of Personal Representative’s Authority**

**NOTICE: The office of the general counsel of the Texas Medical Association provides this information with the express understanding that 1) no attorney-client relationship exists, 2) neither TMA nor its attorneys are engaged in rpviding legal advice and 3) that the information is of a general character. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought.**

**Katy Hand & General Surgery, P.A.**

**Faranak Vossoughi, M.D.**

19255 Park Row Suite 202

Houston Tx 77084

281-693-HAND (4263)

**Office Policies and Procedures**

**Appointments:** Office hours are by appointment only. In scheduling appointments, it is our intent to see you as soon as possible. Our staff and physicians will make every effort to accommodate urgent add on requests. Please be aware that due to the nature of our surgical practice, emergencies are common and may cause delays. As a surgical practice, our physicians are not in the office every day, and due to the nature of your need, you may be seen by our Physician Assistant or another designated physician. We allow 15 minutes prior to your appointment to complete the registration process. We will make every effort to see you on time at your scheduled visit. Individuals arriving early for their appointments may not be taken until the scheduled time, to avoid delaying other patients unnecessarily. For your appointment please bring with you all medical reports, x-rays, scans, etc that need the doctor's review during your consultation. Patients are expected to bring these upon arrival to the office the day of the appointment. Due to experience with these items getting delayed if sent through the mail, we prefer the patient obtain these materials and bring them the day of their appointment.

**Cancellations:** We reserve your appointment exclusively for you. We would request 48 hours’ notice for rescheduling and/or cancellation of an appointment so that another patient on our waiting list may be able to utilize this slot. **For appointments cancelled with less than 48 hours’ notice, a cancellation fee of $100.00 will be charged**.

**Forms:** For your convenience we have our standard office forms available online here. Patients may download and fill these forms out prior to their office visit. Please note that depending on the nature of your consultation, it may be necessary to complete additional forms upon your arrival in the office.

**Physician/Clinical Phone Calls:** Your calls will be routed to the appropriate Clinical staff. Complete messages may be taken as needed. Please let them know where you may be reached, including both day and evening numbers. Your call will be returned at the first opportunity. Urgent calls will be immediately routed to the designated Clinical staff and prioritized accordingly.

**Prescription Refills:** For refills, we ask that you provide at least 72 hours’ notice. Please call the Pharmacy and request them to call our office for authorization on the refill. This will facilitate your request in a more timely manner. The Clinical staff will submit your request to your physician. Once the refill has been authorized, it will be called to your pharmacy. If there is a problem with the request, you will be notified by the Clinical staff. For lost narcotic medications or prescription, you have to bring a police report before new medication maybe prescribed.

**Patient Identification:** For your protection and security, photo identification will be requested at the time of treatment, as well as medical records release.

**Surgical Scheduling:** After you have consulted with the doctor and surgery is indicated, our Surgical Coordinator will assist you in coordinating all aspects, including pre-operative testing and understanding insurance/financial responsibilities, of your surgery**. Our office charges a $200.00 fee for cancellations less than 72 hours prior to your procedure.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Name Signature and Date

**Katy Hand & General Surgery, P.A.**

**Faranak Vossoughi, M.D.**

19255 Park Row Suite 202

Houston TX 77084

281-693-HAND (4263)

Fax: 281-693-4265

As of Tuesday March, 19 2013, Katy hand and general surgery will be using

***Patient Portal*.**

This featuure is online and you as a patient will be able to access medical records, scedule appointments, ask for prescription refils ( Only for medications Dr. Vossoughi has prescribed), ect.

In order for access to patient portal we are requiring your e-mail address. After your e-mail is entered into our systems, a confirmation e-mail will be sent to you shortly after. In the e0mail you will recieve your user name and your temporary password, then you will be able to access your patient portal.

We will not sell nor share your e-mail with any third party without your consent. The patient portal is highly secure. We are encouraging all our patients to register.

Please provide your e-mail:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am giving permission to Katy hand and General Surgery to use my e-mail address for only the purpose of Patient portal and to update my electronic medical record. I also understand that after i give my e-mail address, I will recive a confermation e-mail giving me my Patient Portal username and temporary password.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 Patient signature Date

**Katy Hand & General Surgery, P.A.**

**Faranak Vossoughi, M.D.**

19255 Park Row Suite 202

Houston TX 77084

281-693-HAND (4263)

Fax: 281-693-4265

**Release of Diagnostic Imaging**

# And/Or Medical Records

## Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the release of my X-Rays and any other information on my patient file to the above Katy Hand & General Surgery, P.A.**

###  **Patient Signature Date**