Medicare Patient Registration Form
The Hand Center of Southern California

Patient Name_____ Date of Birth_____

Address _____Apt #_____

City _____ State _____ Zip Code_____

Home Phone Number _____

Mobile Phone Number _____

Work Phone Number _____

Email Address _____

Emergency Contact_____

Phone Number _____ Relationship_____

Employer_____Occupation_____

Address_____

City _____State_____Zip Code_____

Referring Physician _____Phone Number_____

Diagnosis _____

I understand that regardless of any insurance coverage which I may have, I am directly responsible to the Hand Center of Southern California for any medical fees due to them. I authorize payment of medical benefits directly to them and authorize release of medical information necessary to process my insurance claims. I agree that a photocopy of this form may be used in lieu of the original.

Signature _____ Date _____

2025

Information Release Authorization

Company Name: The Hand Center of So Cal

I hereby consent to the release and disclosure of my personal health information to:

Name: The Hand Center of So Cal.

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: ( )_____ **Fax #: ( )**_____

For the following purpose:

_____

_____

_____

This release authorization includes my personal health information consisting of:

_____

_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of the above practice having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

_____

Patient Name

_____

Signature ***Date***

2025

PATIENT INFORMATION ACKNOWLEDGMENT FORM

COMPANY NAME: The Hand Center of So Cal

I have read and fully understand above named practice's Notice of Information Practices. I understand that above named practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that above named practice will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in above named practice's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

I also authorize above named practice to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____
Patient Name

_____
Signature

_____
Date

2025 INSURANCE COVERAGE

Company Name: The Hand Center of Southern California

Patient Name: _____

Insurance Company: Medicare

ID Number: _____

Deductible: $257.00 Amount Met: _____

Coverage: _____

Limitations: _____

Please review the above insurance information, which was verified with your insurance company.

Please note: Insurance companies often change their policies and coverage at the beginning of the New Year. As a reminder you are responsible for any amount applied toward your deductible and any amount not covered, for any reason, by your insurance company. We strongly recommend that you check with your insurance company to confirm your physical, occupational, and speech therapy benefits for 2025.

IT IS YOUR RESPONSIBILITY TO INFORM OUR OFFICE REGARDING ANY CHANGES.

Signature: _____ Date: _____

2025

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

Company Name: The Hand Center of So Cal

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date

2025 Patient Signature

COMPANY NAME: The Hand Center of So Cal

PATIENT NAME: _____

____ *Consent for Care and Treatment*

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

____ *Authorization for Signature on File and Release of Information*

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

____ *Authorization for Assignment of Benefits*

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to above named practice.

____ *Financial Responsibility*

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

____ *Cancellation Policy*

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees.

____ *Reminder Message*

I, the undersigned, hereby authorize the office of above named practice to send reminders to my mobile number, home phone, or email address of upcoming appointments.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date