THE HAND AND WRIST INSTITUTE

PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"Patient/Guardian" shall be understood to mean_____.
(name)

"Physician" shall be understood to mean John T. Knight MD/The Hand and Wrist Institute PA.

I understand that I am entering a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Board of Orthopedic Surgery.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Academy of Orthopedic Surgery and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire, and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses, and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery, or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business.

Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it

_____ _____
Physician Patient/Guardian

_____ _____
Effective from Date of Treatment Date of Signature

O| 817.382.6789 **F|** 817.527.8557
510 E. SOUTHLAKE BLVD. SUITE 140 – SOUTHLAKE, TX 76092
www.handandwristinstitute.com

Notice of Privacy Practices
(Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare provider. An example of this would be a physical examination.**
- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.**
- **Healthcare operations include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.**

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respecting to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative mean or at alternative locations.**

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- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy our protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms in our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post (and you may request) a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information. For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201 (202) 619-0257
Toll Free: 1-877-696-6775

“Federal law prohibits this practice from sending you texts or email which are unencrypted or "unsecure." However, many patients find it convenient to communicate with our office by traditional text and/or email. Those modes of communication are generally not considered “secure.” Some patients appreciate the tradeoff between ease of use / convenience and security. We want to accommodate your preferences. If you would like to communicate with us by "unsecure" text or email, please confirm below by providing your authorization. We will keep your preferences in force with no current expiration date until we learn otherwise. Obviously, you can change your mind at any point down the road. Just let us know in writing so we can stay updated with your preference(s). If messages are sent through such channels, they may no longer be protected by HIPAA. Finally, whether or not you decide to use email or text messaging, your choice will have no impact on our decision to treat you. We are here for you.

I authorize for the practice to communicate with me by "unsecure" email; that email address being: _____ (email address)
_____(signature/date)”

Forms:
I understand that there is a charge of $25.00 for any forms I may need the doctor to fill out for me. All forms will be processed in 5-7 business days.

No Show Policy:
There will be a charge of $40.00 for all missed appointments if they are not canceled or rescheduled at least 24 hours in advance. In case of surgery, the notice period is 72 hours and the fee are $250.00

Date: _____ Signature: _____

Assignment of Medical Benefits:
I authorize payment of medical benefits to be paid directly to the above identified physicians for professional services provided. I understand that I am responsible for any deductible, co-insurance, or co-payment according to the terms of my insurance plan. If this is a motor vehicle accident for a third-party liability, I, as the patient, am responsible for all charges not paid by my insurance company. I acknowledge that this office does not bill third-party payers.

Date: _____ Signature: _____

I certify that the injury for which I am being treated is not the result of motor vehicle accident or personal injury and that there is no litigation pending or in process regarding this injury.

Date: _____ Signature: _____

PLEASE NOTE

Due to the nature of the Doctor's schedule, and in order not to inconvenience other patients, you will be permitted to ten-minute grace period. If you are (or will be) more than ten minutes late to your appointment, please call the office to reschedule.

Surgery Candidates:
Please be informed that for any surgical procedure there are three entities that will bill your insurance:

- The surgeon (Dr. Knight)
- The surgery facility
- The anesthesiologist

We are only able to assist you about charges issuing directly from Dr. Knight.

Date: _____ Signature: _____

In Addition:

Dr. Knight performs all surgeries at an ambulatory surgery center, Medical City Frisco & Wise Health Surgical Hospital in Argyle.

Welcome

Please take a few minutes to answer the following questions so that we may better assist you with your healthcare needs.

PATIENT INFORMATION **Date: _____**

Patient:

_____

Last Name ***First Name*** ***Middle***

Address:

_____

_____

City ***State*** ***Zip***

Birth Date: _____ **Patient SS#: _____ - _____ - _____**

Employer: _____ **Business Phone: (_____) _____ - _____**

Business Address: _____ **Occupation: _____**

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home: (_____) _____ - _____Cell: (_____) _____ - _____

Email:

_____

Best time and place to reach you?

_____

Pharmacy information: -

_____

In case of emergency, who should we contact?

Name: _____ **Relationship: _____**

Home: (_____) _____ - _____ **Work: (_____) _____ - _____**

Patient Medical History

Patient Name: _____ Birth Date: _____ Sex: M F

Today's Date: _____ Date of Injury: _____ Are You: Right-handed Left-handed

Primary Care Physician: _____ Phone: (_____) _____ - _____

Is this work related? Yes No
Was it reported? Yes No

Were you sent to our office by a physician? Yes No If so, please provide:

Requesting Physicians' Name: _____ Phone: (_____) _____ - _____

Physician's Address: _____ City/State: _____

History of Present Illness: **Problem: Right Extremity Left Extremity**
Ht: _____'_____" Wt: _____lbs Age: _____

Location: _____ Quality: _____
(Where is the pain/problem? Does it travel to other areas?) **(Is the pain dull, throbbing, and sharp? If lump, is it warm, tender, red?)**

Severity: _____ Duration: _____
(How severe is the pain on a scale of 1-5 with 5 being most severe?) **(How long have you had this pain/problem? When did it start?)**

Timing: _____ Context: _____
(Does the pain/problem occur at a specific time? Is it rare, intermittent, constant?) **(What were you doing at the onset of this pain/problem?)**

Associated Signs/Symptoms: _____
What other associated problems are you having (numbness, bladder or bowel complaints, abnormal sounds- Cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain)?

Modifying factors: _____
What makes the pain/problem worse or better (activities)?

Have you seen any other physicians regarding this condition prior to coming to our office? Yes No

Doctor	When	Tests	Results	Treatment

History of Present Illness:
Have you ever experienced any injury or symptoms regarding this body part? Yes No

If so, please provide details:

_____

_____

Please list any hobbies/sports you enjoy: _____

_____

Which of the above activities are you unable to perform due to your pain? _____

_____

Past Medical History: Have you ever had any of the following? Please check all pertinent boxes

Aids or HIV+	**Bronchitis**	**Hepatitis**	**Mumps**	**Thyroid Disease**
Anemia	**Chicken Pox**	**High Blood Pressure**	**Pneumonia**	**Tuberculosis**
Arthritis	**Diabetes**	**Infectious Mono**	**Polio**	**Ulcer**
Asthma	**Diphtheria**	**Kidney Disease**	**Rheumatic Fever**	**Venereal Disease**
Back Trouble	**Epilepsy**	**Low Blood Pressure**	**Scarlet Fever**	**Whooping Cough**
Bladder Infection	**Glaucoma**	**Measles**	**Sleep Apnea**	**Other (Please List)**
Bleeding Tendency	**Heart Disease**	**Migraine Headaches**	**Smallpox**	
Blood Transfusions	**Hemorrhoids**	**Mitral Valve Prolapse**	**Stroke**	

Medications: Include non-prescription & herbal supplements

Drug Name	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Medication	**Reaction**	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
Tape Allergy	**Yes**	**No**
Latex Allergy	**Yes**	**No**

Past Surgical/Hospitalization History:

Date	**Surgery/Illness**	**Doctor**	**Hospital, City, State**
_____			
_____			
_____			
_____			

Patient Social History:	**Marital Status**	**Use of Alcohol**	**Use of Tobacco**	**Living Situation**
	Single	**Never**	**Never**	**With family**
	Married	**Rarely**	**Previously, but quit**	**With friends**
	Divorced	**Moderate**	**Currently**	**Alone**
	Widowed	**Daily**		**Other**
	Separated		**___Packs per day**	

Family Medical History:

	Age	**Conditions or Diseases**	**If Deceased, Cause of Death**
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____
Social Security Number _____

1. I acknowledge that The Hand and Wrist Institute has provided me with a written copy of their Notice of Privacy Practices. _____ (initial)

2. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions. _____ (initial)

3. I acknowledge that The Hand and Wrist Institute will disclose my protected health information to a family member, other relative, close friend, or any other person I identify that directly relates to that person's involvement in my care. _____ (initial)

Person(s) _____ _____
(Name) (Relationship)

OR

I object to the disclosure of my protected health information to a family member, other relative, close friend, or any other person. _____ (initial)

4. I acknowledge that The Hand and Wrist Institute may communicate with me via US mail, home phone number, or cell phone number. _____ (initial)

5. I request for an alternative method of communication such as alternative address or work phone number. _____ (initial)

   Alternative method:
   _____

_____ _____
Patient Signature **Date**

_____ _____
Personal Representative Signature (if applicable) **Relationship to Patient**

Authorization for Use or Disclosure of Protected Health Information

Pt. Name: _____
SS#:_____
DOB: _____ Phone number: _____
Address: _____ City: _____
State: _____ Zip Code: _____

I hereby authorize _____to use or disclose my protected health information as indicated below to:

Name: _____
Phone number: _____ Fax: _____
Address:_____ City: _____
State: _____ Zip Code: _____

Information to be released:

From & Dates: _____

_____ Copy of complete records

_____ Information related to HIV testing results

_____History and Physical/Consultation reports

_____ Laboratory, X rays, PFT, Echo, Angio, OP reports

_____ Other

I understand that this health information includes HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am specifically authorizing the release of information relating to:

_____Substance Abuse (including alcohol/drug abuse
_____Mental Health
_____Psychotherapy Notes
_____HIV related information (including AIDS related testing)

_____ _____
Signature of Patient or Legal Guardian Date

Purpose of Disclosure:

____ Changing Physician ____ Second Opinion
____ Continuing Care ____ Legal
____ At my (patient) request ____ Insurance
____ Worker's Compensation ____ School
Other: _____

1. I understand that this authorization will expire two years from last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer at the address indicated below in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form
5. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature: _____ Relationship:_____ Date: _____
Patient or representative

Witness: _____ Date: _____