Volusia Hand Surgery Clinic, PA

Excellence in Hand Care
www.volusiahandsurgery.com

Tamara R. Clancy, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Srikanth Eathiraju, M.D.
Board Certified General Surgery
Subspecialty Certificate in Surgery of the Hand

Sarah E. Henry, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

New Cancellation Policy starting 01/01/2021

1. (NEW PATIENT) appointments- No call/ No show or canceled less than 24 hours in advance will have a $50.00 fee billed to the account. This fee must be paid before another visit will be made.

2. (Established Patient)- No show/No call there is a $25.00 fee. This fee must be paid before another visit will be made.

3. If scheduled (surgery) is canceled less than 48 hours in advance without reason, there will be a $100.00 fee. This fee must be paid before surgery is rescheduled or another visit is made.

4. New Problem or over 1 year (20min Visits) Returning patient. $50.00 fee for less than 24-hour cancelation or No Call/ No Show.

5. 2nd Opinion 30 min visits $100.00 fee for a cancellation in less than 24-hour or No Call/ No Show.

3635 S. Clyde Morris Blvd, Ste 900
Port Orange, FL 32129
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4
Palm Coast, FL 32137
(386) 246-3063

239 N. Ridgewood Ave, Ste 1
Edgewater, FL 32132
(386) 410-4972

2777 Enterprise Rd, Bld 2
Orange City, FL 32763
(386) 218-4920

FAX: (386) 788-0679

Volusia Hand Surgery Clinic, PA

Excellence in Hand Care
www.volusiahandsurgery.com

Tamara R. Clancy, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Srikanth Eathiraju, M.D.
Board Certified General Surgery
Subspecialty Certificate in Surgery of the Hand

Sarah E. Henry, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Meaningful Use Patient Form

Name _____ Date _____

Email _____

Please circle one:

Ethnicity:
Hispanic or Latino
Not Hispanic or Latino
Unknown

Race:
American Indian or Alaska Native
Asian
Black or African American
Hawaiian Native or Pacific Islander
Multiple
Other
Unknown
White

Smoking Status:
Current every day Smoker
Occasional smoker
Former Smoker
Never Smoker

Preferred Language _____

Primary Care Physician _____

Referred by _____

3635 S. Clyde Morris Blvd, Ste 900
Port Orange, FL 32129
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4
Palm Coast, FL 32137
(386) 246-3063

239 N. Ridgewood Ave, Ste 1
Edgewater, FL 32132
(386) 410-4972

2777 Enterprise Rd, Bld 2
Orange City, FL 32763
(386) 218-4920

FAX: (386) 788-0679

VOLUSIA HAND SURGERY CLINIC, PA
Tamara Ray Clancy, M.D.
Srikanth Eathiraju, M.D.
Sarah E. Henry, M.D.

Appointment Date: _____DATE OF INJURY_____ Place of Injury_____

Have you previously been treated by Dr. Clancy, Dr. Eathiraju or Dr. Henry? _____No _____Yes.

_____ ____ _____
FIRST MI LAST

_____
STREET (Please include apt. # if applicable)

_____ _____ _____
CITY STATE ZIP CODE

_____ _____ _____
Phone# Age Date of Birth

_____ _____ _____
Work Phone# Ext# Social Security#

_____
Spouse's Name/Parent's name: (If child is under 18 years of age)

_____
Emergency Contact Name and Phone Number

******PAYMENT IS EXPECTED AT TIME OF SERVICE*****

Insurance Company Name: _____ Preferred Lab_____

_____ _____
Policy Holder's NAME INSURED ID# AND GROUP #

_____ _____
Policy Holder's DATE OF BIRTH Policy Holder's S.S. #

_____
Pharmacy Name Address phone # Fax #

_____ _____
REFERRED BY PATIENT PRIMARY CARE PHYSICIAN

I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident and I hereby irrevocably assign to the doctor all payments for medical services rendered. I also request that authorized medical benefits be made on my behalf to the physician indicated above. I understand that I am financially responsible for all changes whether or not covered by insurance and for collection fees that may be incurred.

_____ _____
Signature of Responsible Party Date

Chief Complaint

Why are you seeing the doctor today? _____
How are where did the injuries occur? _____

Current problem is the result of a (n): Check all that apply
( ) Car accident
( ) Work Accident
( ) Accident
( ) Other

Medications/Supplements/Over-the-counter	Dosage/Times per day	Reason for Medication

Last Tetanus immunization _____ Covid-19 vaccine or booster in the last 2 weeks? _____
Are all immunizations up to date? _____ Yes ____ No
If no, which immunizations are due? _____

Chronic Illnesses (Please Circle)

High blood pressure	Yes	No	Diabetes Type 1 or 2	Yes	No
Asthma	Yes	No	Hepatitis A, B or C	Yes	No
Tuberculosis	Yes	No	Phlebitis	Yes	No
Thyroid disease	Yes	No	Heart Attacks	Yes	No
Type _____			Arrhythmia	Yes	No
Anemia	Yes	No	Strokes	Yes	No
Bleeding disorder	Yes	No	Cancer	Yes	No
Type _____			Type _____		
Seizure disorders	Yes	No	Ulcers	Yes	No
Kidney disease	Yes	No	Birth defects	Yes	No
Arthritis	Yes	No	HIV/AIDS	Yes	No
Type_____			Covid-19 Vaccinated	Yes	No
High Cholesterol	Yes	No			

ALLERGIES

Past Medical History

Surgeries/Hospitalizations	Year/Physician	Complications?

Last EKG _____ Cardiologist Name _____ Date of last labwork/Where _____

Have you ever had general anesthesia? Yes____ No____

Have you ever had problems with anesthesia? No____ Yes____ Explain _____

Family History

Member		Alive	Deceased	Age	Health status/cause of death
Father	A	D			
Mother	A	D			
Sister/Brother	A	D			
Sister/Brother	A	D			
Sister/Brother	A	D			

Vital signs: HT _____ PN Level _____/10 W _____ BP_____/ _____

T_____ P_____ R_____

Social History

Smoker ____No _____ Yes Former Smoker Yes ___ No ____ How much, what do you smoke? ____

Have you used drugs other than for medical reasons in the past 12 months, if so what? _____

Do you drink alcohol? __ No __ Yes, if yes __ monthly or less ___ 2-4x month ___ 2-3x week __ 4 or more x week How many drinks_____ ever 6 or more_____

Marital Status: Single ___Married ___ Partner ____ Divorced ___ Widowed _____

N0# of Adults ____ Children ___ in the home.

Level of Education _____ Employed _____Yes ___ No

If yes, what is your occupation? _____

Review of Systems (Please Circle)

Are you currently having or have you had problems with your:

Chills	No	Yes	Prolonged bleeding	No	Yes
Fatigue	No	Yes	Muscle aches	No	Yes
Fever	No	Yes	Painful joints	No	Yes
Weight gain	No	Yes	Swollen joints	No	Yes
Weight loss	No	Yes	Cold extremities	No	Yes
Diminished vision	No	Yes	Decreased sensation in extremities	No	Yes
Weakness	No	Yes	Keloid formation	No	Yes
Chest pain	No	Yes	Skin cancer	No	Yes
Sputum production	No	Yes	Skin lesions	No	Yes
Chest pain with exertion	No	Yes	Loss of strength	No	Yes
Dizziness	No	Yes	Memory loss	No	Yes
Fluid accumulation in the legs	No	Yes	Seizures	No	Yes
Irregular heartbeat	No	Yes	Tingling/Numbness	No	Yes
Shortness of breath	No	Yes	Tremor	No	Yes
Abdominal pain	No	Yes	Depressed mood	No	Yes
Diarrhea	No	Yes	Difficulty sleeping	No	Yes
Nausea	No	Yes	Mental or physical abuse	No	Yes
Vomiting	No	Yes	Substance abuse	No	Yes
Anemia	No	Yes			

Describe all **YES** responses: _____

_____

Patient Signature: _____ Date: _____

Reviewed By: _____ M.D. Date:_____

Volusia Hand Surgery Clinic, PA

Excellence in Hand Care
www.volusiahandsurgery.com

Tamara R. Clancy, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Srikanth Eathiraju, M.D.
Board Certified General Surgery
Subspecialty Certificate in Surgery of the Hand

Sarah E. Henry, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Notice of Privacy Practices Acknowledgement

Patient Name: _____

Date of Birth: _____ SSN: _____

By signing this form, you have acknowledged that we have provided you with our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. We must try to obtain your written acknowledgement on your first date of service after April 14, 2013. If your first date of service with us was due to an emergency, we must try to provide you with our notice and get your written acknowledgement for the notice as soon as we can once the emergency has passed.

Please check all that are true:
( ) I have received the Notice of Privacy Practices (effective 9/23/2013)

_____ _____
Patient or Legal Representative Date

_____
Relationship of Legal Representative

For Office Use Only

To be completed only if Acknowledgement is not signed.

1. Was the patient given a copy of the Notice of Privacy Practices?
   ( ) yes ( ) no
2. Please explain why the patient was unable to sign this Acknowledgement and our efforts in trying to obtain the patient's signature:

_____

_____

_____ _____ _____
Signed Name/Title Date

3635 S. Clyde Morris Blvd, Ste 900
Port Orange, FL 32129
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4
Palm Coast, FL 32137
(386) 246-3063

239 N. Ridgewood Ave, Ste 1
Edgewater, FL 32132
(386) 410-4972

2777 Enterprise Rd, Bld 2
Orange City, FL 32763
(386) 218-4920

FAX: (386) 788-0679

Volusia Hand Surgery Clinic, PA

Excellence in Hand Care
www.volusiahandsurgery.com

Tamara R. Clancy, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Srikanth Eathiraju, M.D.
Board Certified General Surgery
Subspecialty Certificate in Surgery of the Hand

Sarah E. Henry, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

IMPORTANT INFORMATION REGARDING INSURANCE BILLING

Our doctors are here to provide you with the best medical care. Their primary concern is your health and well-being, not your insurance company. Therefore, it is the patient's responsibility to be aware of what their policy covers.

It is very important for you to read your insurance policy very carefully. As we participate with numerous insurance companies and each company has many different plans, we cannot possibly be aware of each patient's particular coverage. You will receive a bill if the service is one that is not covered under your policy. It is important that you are familiar with the benefits and policies of your insurance.

I have read the above and understand that I am responsible for knowing the coverage and benefits of my insurance policy as well as choosing a lab that my insurance company participates with.

Patient Signature _____ Date _____

3635 S. Clyde Morris Blvd, Ste 900
Port Orange, FL 32129
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4
Palm Coast, FL 32137
(386) 246-3063

239 N. Ridgewood Ave, Ste 1
Edgewater, FL 32132
(386) 410-4972

2777 Enterprise Rd, Bld 2
Orange City, FL 32763
(386) 218-4920

FAX: (386) 788-0679

Volusia Hand Surgery Clinic, PA

Excellence in Hand Care
www.volusiahandsurgery.com

Tamara R. Clancy, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Srikanth Eathiraju, M.D.
Board Certified General Surgery
Subspecialty Certificate in Surgery of the Hand

Sarah E. Henry, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer and **E-FORCSE,** Electronic-Florida Online Reporting Of Controlled Substances Evaluation.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for Volusia Hand Surgery to obtain my medication history from my pharmacy, my health plans, E-FORCSE, and my other healthcare providers.

Name:_____

Signature:_____

Date:_____

3635 S. Clyde Morris Blvd, Ste 900
Port Orange, FL 32129
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4
Palm Coast, FL 32137
(386) 246-3063

239 N. Ridgewood Ave, Ste 1
Edgewater, FL 32132
(386) 410-4972

2777 Enterprise Rd, Bld 2
Orange City, FL 32763
(386) 218-4920

FAX: (386) 788-0679

Volusia Hand Surgery Clinic, PA

Excellence in Hand Care
www.volusiahandsurgery.com

Tamara R. Clancy, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Srikanth Eathiraju, M.D.
Board Certified General Surgery
Subspecialty Certificate in Surgery of the Hand

Sarah E. Henry, M.D.
Board Certified Orthopaedic Surgery
Subspecialty Certificate in Surgery of the Hand

Authorization for the Release and/or Discussion of Protected Health Information

Patient Name: _____ SS# ___-__-____ Birth Date ___/___/____

Authorization

1. I, _____, hereby authorize
2. Name of person or organization: _____

   Street Address : _____

   City, state, zip : _____ Telephone : ( ) _____
3. A. To release and/or discuss the following information

   Complete Record | Outpatient Care | Inpatient Care

   X-Ray Results | Laboratory Results | Treatment Plan Update

   Other _____

   If my record contains the following information, it is also released if *CIRCLED* below:

   Substance Abuse | Mental Health Treatment | HIV Testing or Treatment
4. To _____ of Volusia Hand Surgery Clinic, PA
   3635 South Clyde Morris Blvd Suite 900
   Port Orange, FL 32129

   This information release is at my request for the purpose of legal assistance.
5. Signature :

   I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

   I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

   This authorization expires _____ 6 months _____ one year from today's date, or upon the following specific event: _____.

   I authorize the use of a copy of this form for the disclosure of the information described above.

Signed _____ Relationship _____ Date: ___/___/___

Sent by initials _____

3635 S. Clyde Morris Blvd, Ste 900
Port Orange, FL 32129
(386) 788-HAND (4263)

315 Palm Coast Parkway, NE, Ste 4
Palm Coast, FL 32137
(386) 246-3063

239 N. Ridgewood Ave, Ste 1
Edgewater, FL 32132
(386) 410-4972

2777 Enterprise Rd, Bld 2
Orange City, FL 32763
(386) 218-4920

FAX: (386) 788-0679

TELEMEDICINE PATIENT CONSENT/REFUSAL FORM

PATIENT NAME: _____

DATE OF BIRTH: _____ ID#: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following procedure(s) and/or service(s)

   _____

   _____

2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)
3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Florida state law apply to information disclosed during this telemedicine consultation.
5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Florida, and that Florida law shall apply to all disputes.
7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telemedicine consultations for the procedure(s) described above.
Signature: _____

If signed by someone other than the patient, indicate relationship: _____
I refuse to participate in a telemedicine consultation for the procedure(s) described above.
Signature: _____

If signed by someone other than the patient, indicate relationship: _____

DATE: _____ TIME: _____

WITNESS: _____

DATE: _____ TIME: _____