Scott Wolfe, M.D.

PATIENT INFORMATION

LEGAL NAME: _____

PREFERRED NAME (if applicable): _____

ADDRESS: _____

CITY, STATE: _____

ZIP CODE: _____

HOME PHONE: _____

WORK PHONE: _____ EXT: _____

CELL PHONE: _____

EMAIL: _____

PATIENT EMPLOYMENT

EMPLOYER: _____

OCCUPATION: _____

PHONE: _____ EXT: _____

GUARANTOR (The primary insurance policyholder)

☐ Same as patient

GUARANTOR NAME: _____

ADDRESS: _____

CITY, STATE: _____

ZIP CODE: _____

PHONE: _____

GUARANTOR'S Relationship to patient: _____

SOCIAL SECURITY#: _____

DATE OF BIRTH: _____

GUARANTOR EMPLOYMENT (if not patient)

EMPLOYER: _____

OCCUPATION: _____

PHONE: _____ EXT: _____

HSS# (Official use only): _____

TODAY'S DATE: _____

DATE OF BIRTH: _____ SEX: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ OTHER

SOCIAL SECURITY#: _____

REFERRING PHYSICIAN: _____

PHONE NUMBER: _____

PRIMARY PHYSICIAN: _____

PHONE NUMBER: _____

PHARMACY NAME: _____

PHONE NUMBER: _____

ADDRESS: _____

CITY, STATE: _____

ZIP CODE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

ADDITIONAL INSURANCE: _____

EMERGENCY CONTACT

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

New Patient Evaluation Form
Scott Wolfe, MD

Today's Date: _____

Name: _____ Date of Birth: _____

History of Current Complaint:

1. Which side is affected? ☐ Right ☐ Left ☐ Both
2. Which hand do you write with? ☐ Right ☐ Left ☐ Both
3. Reason for today's visit? _____
4. For how long? _____

Past Medical History:

- ☐ High blood pressure
- ☐ High Cholesterol/Lipids
- ☐ Coronary artery disease (CAD)
- ☐ History of heart attack (MI)
- ☐ Congestive Heart Failure (CHF)
- ☐ Atrial Fibrillation
- ☐ Diabetes mellitus (type I or II)
- ☐ Hyper/hypothyroidism
- ☐ Hyperparathyroidism
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Kidney Disease
- ☐ Sleep Apnea
- ☐ Rheumatoid Arthritis
- ☐ Psoriatic Arthritis
- ☐ Psoriasis
- ☐ SLE / Lupus
- ☐ Peptic Ulcer Disease
- ☐ GERD / Reflux
- ☐ IBD: Crohn's or UC
- ☐ Hepatitis
- ☐ History of Stroke or TIA
- ☐ Seizure Disorder
- ☐ Parkinson's disease
- ☐ Anemia
- ☐ Cataracts/Glaucoma
- ☐ Cancer, Type: _____
- ☐ History of Substance Abuse
- ☐ Weight loss/Weight gain
- ☐ Fever/Sweats/Chills
- ☐ Other: _____
- ☐ Metal implants in body?

  Where? _____

Medications:

Medication	Dosage	Medication	Dosage
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Surgeries:

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

Allergies:

Allergy	Reaction	Allergy	Reaction
1.		3.	
2.		4.	

Social History:

Occupation: _____ Alcohol Intake: _____ Drinks/week

Smoking: ☐ Prior Smoker, Quit: _____ ☐ Current Smoker, # of Packs per day: _____ x _____ years

Vital Signs: (for official use only)

Height: _____ Weight: _____ BP: _____ Pulse: _____ Temp: _____

HIPPA Release- Individual Authorization
NOTICE OF PRIVACY PRACTICES

We are committed to protecting the privacy of your health information. Because of this commitment we must obtain your written authorization before we may use or disclose your protected health information for the purpose(s) described below. Please read the information below carefully before signing this form.

Who will disclose your health information? **Dr. Scott Wolfe and his staff.**

What information will be used or disclosed? ☐ All or ☐ Other: _____

Who do you authorize to have access to your health information? Name(s): _____

_____

When will this authorization expire? Date: ☐ 2 years or ☐ Other _____

You should note that when your protected health information is disclosed to people or entities that are not required to abide by federal or state medical privacy laws, those people or entities may re-disclose your information to others and use your information without being subject to penalties under those laws. What is the purpose of the use or disclosure? **At the request of the individual.**

If applicable, which of the following information, can be disclosed?
☐ Substance Abuse ☐ Psychiatric/Psychotherapy Care ☐ Sexually Transmitted Disease ☐ Tuberculosis ☐ Genetic Information ☐ HIV Related Information
HIV related information is any information indicating that you have had an HIV-related test or have HIV infection. HIV related illness or AIDS or any information which could indicate that you have been potentially exposed to HIV. If you are authorizing the release of HIV-related information you should be aware that the recipient(s) is prohibited from re-disclosing any HIV-related information without your authorization unless permitted to do so by federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information you may contact the New York State Division of Human Rights at 212-480-2493 or the New York City Commission of Human Rights at 212-306-7450. These agencies are responsible for protecting your rights.

By signing this authorization form you authorize the use or disclosure of your protected health information as described above. You have a right to refuse to sign this authorization. Your health care, the payment for your health care and your health care benefits will not be affected if you do not sign this form. You also have the right to receive a copy of this form after you have signed it. If you sign this authorization you have the right to revoke it at any time except to the extent that our practice has already taken action based upon your authorization. To revoke this form, write to Dr. Scott Wolfe at 535 East 70th St., NY, NY 10021.

Acknowledgement of Receipt of Dr. Wolfe's Privacy Practices

By signing below, I acknowledge that I have been provided my physician's Notice of Privacy Practices. And have therefore been advised of how health information about me may be used and disclosed by this practice and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me and for the business operations of this practice, its physicians and staff.

I have read this form and all my questions about it have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Patient Printed Name: _____

Patient Signature: _____ Date:_____

Guardian/Guarantor/Healthcare Agent Printed Name (if applicable): _____

Guardian/Guarantor/Healthcare Agent Signature: _____ Date:_____

Assignment and Release of Information Statement
I certify that the information given by me is correct. I understand that this information is entered into a database and I authorize the sharing of such information with hospital affiliated physicians and their offices who are responsible for my care. I hereby also authorize the release of information related to my medical care as requested by government agencies and/or insurance carriers. I hereby assign benefits to the physician and understand that in the absence of accepted insurance coverage I or my legal guardian is responsible for full payment of services rendered. This statement shall be effective from the date of the signature below until my insurance changes at which time I will notify Dr. Wolfe's office staff.

Understanding Your Insurance Benefits
Please note it is the patient's responsibility to understand their insurance benefits for all visits, tests, and surgeries. Due to the disparity in each and every patient's insurance, our office is unable to provide any specific information on your insurance benefits including your out of pocket cost for procedures. Our office will try to help as much as possible. Should you have questions regarding your insurance benefits please call the Hospital's Insurance Advisory Service at (212) 774-2607.

Out of Office Policy
If I, Dr. Scott Wolfe, am away on business or on an occasional family trip you will continue to receive the highest level of care. In my absence my patients are most often seen by my physician assistant or our board-eligible hand fellow. I still direct the care that you receive from my associates. Though out of the office, I monitor coverage on a periodic basis from afar and always have an onsite Attending covering me for emergencies. I have complete faith and trust in my office staff and my associates to provide the highest level of care and ask my patients to respect my need to travel, teach, lecture and take an occasional vacation day. If you have any questions regarding this policy, please do not hesitate to contact my office at (212) 606-1529.

Financial Interest Disclosure
Dr. Scott Wolfe performs training sessions to teach physicians the proper techniques for implantation of TriMed and other implants. He receives reimbursement for travel and lecture time from TriMed. He is a consultant and has received a research grant from Conventus Orthopedics, a distal radius implant manufacturer. He receives compensation from Conventus for his lecture and consulting time. He is a consultant for Extremity Medical, LLC from which he receives compensation. He has invented and receives royalties for a new total wrist replacement which is not yet available in the United States. He is also a textbook editor for Elsevier, Inc. and receives royalties on book sales. **Dr. Wolfe does not receive any payments from these companies for use of their products for your care at HSS or for the care of any other patients at HSS.**

You can ask Dr. Wolfe about any questions you may have about these financial interests or you may contact the Hand Service Chief, Dr. Edward Athanasian at 212-606-1962, the HSS Office of Corporate Complaints at 212-774-2398 or HSS Office of Legal Affairs at 212-606-1592. They can address your questions and concerns and provide information about HSS conflict of interest policies before deciding whether to continue with treatment. If because of the financial interest or relationship Dr. Wolfe has disclosed to you, you choose to refuse a particular treatment or wish to revoke any informed consent you have previously given for an operation or procedure, you must sign the hospital's **Refusal to Consent to Treatment** form. In either case you can continue with other treatments at the hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below you acknowledge that Dr. Wolfe has disclosed the financial interests and relationships described above. You also confirm that you have read and fully understand this document, also that you have been given the opportunity to ask questions about Dr. Wolfe's financial interest or relationships and your questions have been answered to your satisfaction.

Patient Printed Name: _____

Patient Signature: _____ Date:_____

Guardian/Guarantor/Healthcare Agent Printed Name (if applicable): _____

Guardian/Guarantor/Healthcare Agent Signature: _____ Date:_____

Patient Payment Responsibilities

Office Visits

If Dr. Wolfe Accepts Your Insurance (You are "in-network"):
You pay your copay at your visit. We submit to your insurance. If your insurance decides you are responsible for additional payments to Dr. Wolfe, we send you a bill for this amount.

If Dr. Wolfe Does Not Accept Your Insurance (You are "out-of-network"):
You pay the full amount charged at your visit. We provide the payment paperwork for you to submit to your insurance company. You may receive some reimbursement if you have out of network benefits.

Dr. Wolfe has opted out of Medicare. We require payment for the full amount charged at your visit. We also require you to sign a contract, prior to your visit, promising that you will not submit Dr. Wolfe's charges to Medicare. If you do so, it will not be paid. You may submit to your secondary insurance, provided it is not a Medicare insurance.

Dr. Wolfe is not a provider for No Fault or Workers Compensation Insurances.

Some Blue Cross Insurance plans will not allow patients to be seen at HSS Stamford. It is the patient's responsibility to determine if this applies. Please call your plan and HSS Insurance Advisory at 212-774-2607 to verify your coverage.

Surgery

If you are "in network", no pre-surgical payment is required. Please call your insurance prior to surgery with the planned procedure codes we provide to understand your financial responsibility prior to surgery. The pre-planned procedures may change during surgery which can affect the final charges.

If you are "out of network", a pre-surgical payment is required one week prior to surgery. We will negotiate an acceptable charge with you that is your responsibility to pay. If you have out of network benefits, please call your insurance prior to surgery with the planned procedure codes we will give you to understand your financial responsibility prior to surgery. The pre-planned procedures may change during surgery which can affect the final charges.

If you have Medicare, full payment is required prior to surgery. You are responsible for the full amount of payment and this charge will not be submitted to Medicare. The Hospital for Special Surgery does participate with Medicare and will submit its bills to Medicare. (Anesthesia, Radiology, Physical Therapy, Splints, Pathology).

If an insurance company sends you payments that are meant for Dr. Wolfe, it is your responsibility to send them on to Dr. Wolfe with all the associated paperwork from the insurance company.

By signing below, you acknowledge that you have read, understood and agreed to the above and that your care is not a worker's comp, no fault or Medicare claim and that if your insurance sends you Dr. Wolfe's payment, you will send it on to him.

Patient Printed Name: _____

Patient Signature: _____ Date:_____

Guardian/Guarantor/Healthcare Agent Printed Name (if applicable): _____

Guardian/Guarantor/Healthcare Agent Signature: _____ Date:_____

If you have Medicare:

Medicare Patient Private Physician Contract

This agreement, entered into the date below, is between **Scott Wolfe, MD,** whose business address is 523 East 72nd Street, NY, NY 10021 and patient named:

Patient Printed Name: _____ DOB: _____

who resides at Address: _____and is a Medicare Part B beneficiary or eligible, seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician decided to opt-out of the Medicare program effective January 26, 2017 and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act. Physician agrees to provide the following medical services to Patient ("Services"): general medical care including but not limited to physicals, chronic and acute disease management, delivery attendance and minor skin surgery or wound care. In exchange for Services, the Patient agrees to make payment directly to Physician.

Patient also agrees, understands and expressly acknowledges the following:

Patient agrees not to submit a claim (or to request Physician to submit a claim) to the Medicare program with respect to the Services for payment, even if covered by Medicare Part B. Initials _____

Patient is not currently in an emergency or urgent health care situation. Initials _____

Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services. Initials _____

Patient acknowledges that secondary or supplemental plans may not provide payment or reimbursement for the Services because payment is not made under the Medicare program. Initials _____

Patient acknowledges that patient has a right, as a Medicare beneficiary, to obtain Medicare covered items/services from physicians and practitioners who have not opted-out of Medicare, and that patient is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted-out. Initials _____

Patient agrees to be responsible to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided. Initials _____

Patient understands that Medicare payment will not be made for any items or services furnished by the Physician that may have otherwise been covered by Medicare if there were no private contract. Initials _____

Patient acknowledges that a copy of this contract has been made available. Initials _____

Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his/her beneficiaries. Initials _____

Executed by Patient or if Patient's Representative

Patient Signature: _____ Date: _____