Phone: (808) 495-5230 Fax: (888) 491-1299

S.C.YOUNG, M.D., C.M., F.R.C.S.

Date: ____________

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL SECTIONS

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other______________ Ethnicity __________________________
EMAIL ADDRESS			
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR

How did you hear about our office? ____

Emergency Contact Information

NAME	PHONE#

Is your visit related to an injury? Yes ☐ No ☐ If yes, is the injury **work related**? Yes ☐ No ☐

If yes, name/address of Employer ______________________________

DATE OF INJURY	CLAIM #

Claim Adjustor/ Case Manager **PHONE**

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to S.C. Young, MD.
I authorize the office of S.C.Young, MD to release any information to my insurance company required to aid in the processing of this claim and all future claims.
I am aware that I am financially responsible for non-covered services and that payment is due at time of service unless prior arrangements are made.

______________________________ ______________________
Signature Date
(If minor parent or legal guardian)

____
Relationship to Patient

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CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize S. C. Young, MD to use and disclose the health and medical information

of ______________________________ for treatment, payment and health care operations.*
(NAME OF PATIENT)

***Treatment** includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and among other health care providers. This consent includes treatment provided by any physician who covers my practice by telephone as the on-call physician. It also may include medical quality assurance and peer review.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** includes the necessary administrative and business functions of our office.

You may receive and review S.C. Young, MD's "Notice Of Privacy Practices" for additional information about the uses and disclosures of information described in this consent prior to signing this consent. Please verify that you have been given an opportunity to read and been offered a copy of our Notice of Privacy Practices by placing your initials here:________.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change also. A summary of the Notice will be posted in the lobby of our office indicating the effective date of the Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this consent, provided that I do so in writing, except to the extent that S.C. Young, MD has already used or disclosed the information in reliance on this consent.

______________________ ____
(Date) Signature of patient

______________________ ____
(Date) Signature of person authorized by law

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S.C.YOUNG, M.D., C.M., F.R.C.S.
HAND SURGERY & CARE

Patient Name: ______________________ D.O.B: _________ Date: ____________

List all medications, vitamins and herbs that you take regularly and/or occasionally.

Name: Dosage: How Often?

____

____

____

List all allergies and/or drug sensitivities. Check here if none. ☐

____

____

Have you had (mark each one)?

	yes	no		yes	no
Jaundice or hepatitis	☐	☐	Lung disease/shortness of breath	☐	☐
Risk of AIDS	☐	☐	Asthma	☐	☐
High blood pressure	☐	☐	Bleeding tendency	☐	☐
Diabetes	☐	☐	Blood disease	☐	☐
*Requiring insulin?	☐	☐	Kidney disease	☐	☐
Epilepsy, seizures	☐	☐	Stomach problems	☐	☐
Depression	☐	☐	Ulcers	☐	☐
Stroke	☐	☐	Gall bladder problems	☐	☐
Bone disease	☐	☐	Bowel disease	☐	☐
Arthritis	☐	☐	Bad reaction to anesthesia	☐	☐
Heart disease/chest pain	☐	☐	Ever taken steroids?	☐	☐
Cancer	☐	☐	Sleep apnea	☐	☐

Poor health for other reasons ______________________________

Could you be pregnant? ________

Weight ________ Height _________

Do you drink alcohol? yes ___ no ___

Regularly use non-prescription drugs? yes ___ no ____

Smoke? yes ____ no ____ how much? _________ quit? _____ when? __________

Family History:
What diseases run in your family? ______________________________

Does anyone in your family have the same problem as you?______________________

Do you live alone? yes ____ no ____ With how many others? __________________

What is your present occupation? _________________Previous __________________

List all surgeries:____

____

Do you have an Advance Directive? yes____ no____

PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing how medical information about you may be used and disclosed and how you can access this information.

- We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

- We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain; amending or correcting that information; obtaining an accounting of our disclosures of your medical information; requesting that we communicate with you confidentially; requesting that we restrict certain uses and disclosures of your health information; and complaining if you think your rights have been violated.

- We have available a detailed notice of privacy practices which fully explains your rights and our obligations under the law. We may revise this notice from time to time. The effective date indicates the date of the most current notice in effect.

- You have the right to receive a copy of our most current notice in effect. If you have not yet received a copy of our current notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the notice or your medical information, please let us know.

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The Office of S.C. Young MD

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

[*Note: You May Refuse to Sign This Acknowledgement*]

I, ____, have read the Notice of Privacy Practices or
(Please print patient or responsible party name)

been given a copy of the Notice of Privacy Practices by the office of S. C. Young,MD.

____ ________________________
Signature of patient or responsible party Date

ANSWERING MACHINE RELEASE FORM

By my signature on this form I, ____give permission for the office of Scott C. Young MD to leave the below checked information on my answering machine and, or voice mail:

- ☐ Appointment or surgery times or reminders
- ☐ Information on treatment to be done or treatment options
- ☐ Payment reminders
- ☐ May release information to spouse or partner
  Name of Spouse or Partner ____________________________________

______________________________ ______________________________ ____________
Please print name Signature Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_______ Individual refused to sign

_______ Communication barriers prohibited obtaining the acknowledgement

_______ An emergency situation prevented us from obtaining acknowledgement

_______ Other (Please Specify):

____

____

Revised 11/12/13

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SCOTT C. YOUNG, MD, CM, FRCS (C) **PH (808) 495-5230**

POLICY ON PATIENT ACCOUNTS

Name:____ Birth date:_________________________

To keep health care costs down while maintaining a high level of professional care, we have established the following payment policies for the convenience of our patients. It is our policy that the responsibility for paying for care will be placed on those who receive it. Therefore, all accounts will be administered under the following guidelines:

1. **Any first-time patient of Dr. Scott C. Young is required to pay for his/her visit on the day of service, if he/she is not covered by health insurance**. If you have a balance on your account you will receive a monthly statement until the account is paid in full.

2. **PAYMENT OPTIONS:** Payment options include cash or check, Visa or MasterCard. Office staff can explain other options available, including patient financing.

3. **INSURANCE PATIENTS:** We will be happy to bill your insurance for you if you provide us with the appropriate billing information. Your insurance will make payment directly to Dr. Young and you will be responsible for any deductible, co-payment, or other patient balances. **Your co-payment is due at the time of service.**

   If your insurance requires a referral, it must be in place before you see the doctor. If it is not in place, you will need to be prepared to pay for your visit.

4. **HOSPITAL CHARGES:** Please remember that any physician services provided by Dr. Young while you are in the hospital will be billed to you or your insurance carrier. The hospital bills you receive will be for services provided by the hospital, not for Dr. Young's services. You may also receive statements from other providers, e.g. a pathologist or physical therapist. These statements are not connected with Dr. Young's services and any questions regarding those services must be referred to the provider responsible for the service.

   If you are to have an office surgery that insurance does not cover or if your procedure is cosmetic, payment is due in full two weeks before the date of the procedure.

5. All bills are due and payable upon receipt of your monthly statement. In addition:

   On balances under $1,000, a minimum monthly payment of 10% of the unpaid balance will be required. If you feel you are unable to pay 10% of your balance, please feel free to discuss this with our Office Manager in order to establish an extension of credit terms. **On balances over $1,000 the balance must be paid in 3 equal monthly payments.** If you are unable to do this, please speak with our Office Manager. Interest will accrue on charges not paid after ninety (90) days of the first billing, at a rate of 1¾ % per month (21% per year) until paid in full.

6. **A $25 fee will be charged for all checks returned for non-sufficient funds.**

7. Past due accounts will be reviewed by the Office Manager for further action and may be assigned to an outside agency for collection. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney's fees.

I HAVE READ AND UNDERSTAND THIS POLICY ON PATIENT ACCOUNTS. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND HAVE RECEIVED A COPY.

____ _______________

Patient / Responsible party Date

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Welcome to Dr. Young's Practice, We are Partners in Healing.

Please commit to your healing, I believe in healing but I need your help. Are you willing to look at all elements and aspects of your healing, Physical, Mental, Emotional and Spiritual?

If you are then I am willing to help you help yourself, because you are a capable and awesome person and I can help you with your commitment.

____________________________ _________________________

Signature Date