EastBayHand Medical Center
(510) 297-0550
(510) 297-0558
www.EBHMC.com
13690 E 14th St #200, San Leandro, CA 94578

PATIENT INFORMATION (PLEASE PRINT)

Name: Last	First	Middle	Maiden	
Home Address: Street	City	State	Zip	
Home Phone: ( )	Cell Phone: ( )	Birthdate:	Social Security Number:	Sex: **M F**
Email Address:				
Patient Occupation:	Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student	Employer:	Business Phone: Ext.	
Employer's Address: Street	City	State	Zip	
Emergency Contact:	Phone Number:	Address:		
Who referred you to our office?	Have you been treated here before? (circle one) Yes No			

FINANCIAL INFORMATION OF RESPONSIBLE PARTY o (CHECK HERE IF SAME AS ABOVE)

Name of responsible party:	Relationship to patient:	Birthdate:	
Address: Street	City	State	Zip
Home Phone: ( )	Social Security Number:	Driver's License Number:	
Occupation:	Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student	Employer:	Business Phone: Ext.
Employer's Address: Street	City	State	Zip

INSURANCE INFORMATION (PLEASE FILL OUT ALL SPACES RELATING TO YOUR COVERAGE)

CHECK TYPE OF COVERAGE		PRIMARY INSURANCE	SECONDARY INSURANCE
o GROUP PLAN	NAME OF THE INSURED		
	NAME OF INSURANCE COMPANY		
o INDIVIDUAL PLAN	BILLING ADDRESS		
	TELEPHONE NUMBER		
o MEDICARE	SUBSCRIBER ID NUMBER		
	GROUP OR LOCAL NUMBER		
o HMO	SOCIAL SECURITY NUMBER		
	BIRTHDATE		
o INDUSTRIAL ACCIDENT	CLAIM NUMBER		

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to East Bay Hand Medical Center of the insurance benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. I also authorize that a photographic copy of this authorization is as if such copy were the original. If it becomes necessary for the account to be referred to a collection agency or an attorney for collection or suit, the undersigned shall pay the reasonable attorney fees and collection expenses.
Worker's Comp Patients are NEVER balance billed and are ONLY responsible for payments if their claim is denied by their WC provider

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Print name of patient, parent, or legal guardian _____ Signature of patient, parent, or legal guardian _____ Date _____

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INITIAL WORKERS COMPENSATION PATIENT QUESTIONNAIRE

Name:_____ **Age**:_____ **Sex**: M F **Date**: _____

Which Hand do you WRITE with: RIGHT LEFT **Height**: _____ **Weight**: _____

Who referred you to this office? _____**Date of injury:** _____

Date you first noticed symptoms: _____

History of Injury: (Please describe symptoms, how the injury occurred, and when symptoms began)

_____

_____

Describe your pain (circle): *Dull / Sharp / Aching / Stabbing / Throbbing / Burning*

What doctors have you seen? _____

What treatment have you had? (circle) *Splint / Injection / Medication / Therapy / Surgery*

How many therapy sessions have you had? _____

What tests have you had? (circle) *X-Ray / MRI / CT Scan / EMG (Nerve Study) / Arthrogram*

Name of Employer: _____

Date hired: _____ If less than 5 years, list prior 2 employers and how long you worked for them:

_____

What is your job title? _____

How many hours per week did you work before the pain started? _____

Describe your work duties (*write/type/lift/overhead work*) _____

_____

How much time have you taken off work for this problem? _____

Describe your work modifications (*lifting limit, limited/no use, etc.*) _____

_____ **When did modifications begin?** _____

List any prior Workers Compensation Claims: _____

Current Medications (please list PRESCRIBED and OVER THE COUNTER): _____

_____

Allergies to medications: No _____ Yes _____ **MEDICATION and REACTION**: _____

_____

Cigarette use: No ____ Quit ____ When ____ Yes ____ Amount _____ (# per day)

Alcohol use: No ____ Quit ____ When ____ Yes ____ Amount _____ (# per week/month)

Medical Conditions: *Diabetes / High Blood Pressure / High Cholesterol / Hypo/Hyper Thyroid*
Rheumatoid Arthritis / Stroke / Seizure / Hepatitis A / B / C / Tuberculosis / Gout / Heart Disease
Heart Attack / COPD / Asthma / Ulcers / Liver Disease / Alcoholism / Osteoarthritis / Bursitis
Blocked Arteries / Depression / Other: _____

Prior Surgeries: (please include all surgeries during your lifetime): _____

_____

_____

Highest grade you completed in school (circle one):

Elementary School Jr. High School High School College (# of years_____)

List your hobbies: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and its 2025 updates, this form documents that you have been provided access to our Notice of Privacy Practices, which describes how your health information may be used and disclosed and how you can access this information.

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices from East Bay Hand Medical Center. I understand that I may request a copy for my records at any time and that the most current version is available upon request at the front desk.

If I have questions about the Notice or my privacy rights, I understand that I may contact the Practice Administrator at (510) 297-0550.

Patient Name (please print): _____ Date: _____

Patient Signature: _____

Parent/Authorized Representative (if applicable): _____ Relationship: _____

Phone Number: (_____) _____ May we leave detailed text/voice messages? ☐ Yes ☐ No

Email Address: _____May we leave detailed messages? ☐ Yes ☐ No

Disclosure of Medical Information:

☐ Patient only (If selected, skip the section below.)

☐ Family member(s) or friend(s) (Please complete below)

Name: _____ Relationship: _____

Restrictions (if any): _____

Name: _____ Relationship: _____

Restrictions (if any): _____

Patient Rights Notice, under HIPAA, you have the right to:

- Inspect and obtain a copy of your health records.
- Request an amendment to your records.
- Receive an accounting of disclosures.
- Request restrictions on certain uses and disclosures.
- Request confidential communications.

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NOTICE OF PRIVACY PRACTICES

EAST BAY HAND MEDICAL CENTER
Effective Date: June 10, 2025
Updated for 2025 HIPAA Compliance

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.

At East Bay Hand Medical Center, we understand that your medical information is personal. We are committed to protecting your privacy and ensuring the confidentiality of your protected health information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and its 2025 updates.

How We May Use and Disclose Your Health Information

Treatment: To provide, coordinate, or manage your medical care with other providers.

Payment: To bill and receive payment from your health plan or other responsible parties.

Healthcare Operations: To improve our services, evaluate staff performance, and conduct business management activities.

Other Permitted or Required Uses:
- As required by law (e.g., public health, reporting abuse)
- For health oversight activities (e.g., audits, investigations)
- To avoid serious threats to health or safety
- For legal proceedings, law enforcement, or national security
- To coroners, medical examiners, and funeral directors
- For organ or tissue donation
- For workers' compensation purposes

Uses and Disclosures Requiring Your Authorization

We will obtain your written permission before using or disclosing your PHI for:
- Marketing communications
- Sale of PHI
- Most sharing of psychotherapy notes
- Disclosures not covered by this Notice

You may revoke an authorization at any time in writing.

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Your Rights Regarding Your Health Information

You have the right to:

1. Access Your Medical Records
2. Request a Correction
3. Receive an Accounting of Disclosures
4. Request Restrictions
5. Confidential Communications
6. Receive a Paper or Electronic Copy of This Notice
7. File a Complaint

Our Responsibilities

- We are required by law to maintain the privacy of your PHI.
- We must provide you with this Notice and abide by its terms.
- We will notify you in the event of a breach of your unsecured PHI.
- We may revise this Notice at any time. Updates will apply to all PHI we maintain.

Changes Due to 2025 HIPAA Updates

- Multi-Factor Authentication (MFA) is required for systems accessing PHI.
- Electronic PHI is encrypted at rest and in transit.
- All staff receive enhanced training on cybersecurity and privacy.
- You have expanded rights to access your data and understand how it is used in AI or digital health technologies.
- Additional protections are in place for reproductive health information.