Name: ______________________

DOB: ______________________

PATIENT INTAKE
COMMERCIAL INSURANCE

PATIENT REGISTRATION FORM

Patient Name: ______________________ Preferred: ______________

Address, City, State, Zip: ______________________________________

____

DOB: ______________________

Email Address: ______________________

Home Phone: ______________________

Cell Phone: ______________________

Work Phone: ______________________

Pronoun (optional): ☐ He ☐ She ☐ They ☐ Ze ☐ Ey

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married Partner's Name: __________

General Physician: ______________________ Referred By: ______________

Have you had Physical Therapy treatment since January of this year? ☐ No ☐ Yes # of Visits: ________

Have you had Chiropractic treatment since January of this year? ☐ No ☐ Yes # of Visits: ________

Have you had Home Healthcare in the last 30 days? ☐ No ☐ Yes

If yes, Home Healthcare Provider: ______________________

Emergency Contact

Name: ______________________ Relationship: ______________

Contact: ______________________

FINANCIAL POLICY

Payment for services is due at the time services are rendered

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Financial Responsibility: ☐ Self ☐ Parent / Legal Guardian Name and DOB ______________

Address and Phone Number, if Different from Above: ______________________

2nd Contact Info and Phone: ______________________ Relation: ______________

______________________________ ______________

Patient / Guardian Signature Date

Name: ______________________

DOB: ______________________

PATIENT INTAKE
COMMERCIAL INSURANCE

COMMERCIAL INSURANCE INFORMATION [if applicable]

Please Note: A copy of your insurance card(s) will be kept on file.
The patient is responsible to provide their most current insurance information.

Primary Insurance: ______________________ Secondary Insurance: ______________________

Group #: __________ Policy #: __________ Group #: __________ Policy #: __________

Subscriber Information: ______________________ Subscriber Information: ______________________

Name: ______________________ Name: ______________________

DOB: ______________________ DOB: ______________________

Relationship to Patient: ______________________ Relationship to Patient: ______________________

WORKER'S COMPENSATION / MOTOR VEHICLE ACCIDENT INSURANCE INFORMATION [if applicable]

What type of insurance do you plan to bill for these services? ☐ Auto Insurance ☐ Worker's Comp ☐ 3rd Party

In addition to providing the Case Information below – if billing your Auto Insurance, please also provide your Health Insurance carrier information and provide a copy of your insurance card

Insurance Carrier: ______________________ Group #: __________

Name of Insured: ______________________ Policy #: __________

Case Information – work related, MVA, personal injury; complete below information

☐ MVA ☐ 3rd Party ☐ WC Date of Accident: __________ State Accident Occurred: __________

Name of Employer / Insured: ______________________ Phone #: __________

Address: ____

Claim or Case #: ______________________ Name of Nurse Case Manager/ Adjustor: __________

Phone # for Nurse Case Manager / Adjustor: ______________________ Fax #: __________

Do you intend to file liability suit or is litigation pending? ☐ Yes ☐ No

If yes, please provide Attorney's Name: ______________________ Phone #: __________

PATIENT ELECT to SELF-PAY FOR SERVICES [if applicable]

If you do not want Hand Therapy Associates to file claims to your personal health insurance, please read and sign below or please indicate if you do not have personal health insurance and sign below.

I acknowledge and understand and agree that:

- ✓ I am covered by the health insurance plan.
- ✓ The Health Plan under which I am covered includes benefits for some or all the services provided by Hand Therapy Associates.
- ✓ Despite the above, I do not wish Hand Therapy Associates to submit a claim to my Health Plan for services provided to me.
- ✓ Until such time as I may otherwise advise Hand Therapy Associates in writing, I elect to pay for all services I receive at their self-pay rates.
- ✓ By election to self-pay for services, I understand that Hand Therapy Associates will not be submitting claims to my Health Plan and that any payments I make to Hand Therapy Associates will NOT be credited toward satisfying any deductibles, plan maximums, etc.
- ✓ I have read the Election to Self-Pay for Services and have had the opportunity to ask any questions I may have, and my questions have been answered to my satisfaction.

☐ I do not have health insurance coverage.

____ ______________________

Patient / Guardian Signature Date

Name: ______________________________

DOB: ______________________________

CONSENT TO TREAT / ASSIGNMENT OF BENEFITS / ACKNOWLEDGEMENTS

I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at Hand Therapy Associates and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to Hand Therapy Associates. I authorize the filing of claims to my insurance plan and authorize Hand Therapy Associates to release necessary health information related to these services to process the claims.

I certify that the information I have provided is accurate and complete.
In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

______________________________ ______________
Patient / Guardian Signature Date

____
Print Name and Relationship to the Patient

AUTHORIZATION FOR COMMUNICATION

By providing my above contact information and signing below, I consent and authorize Hand Therapy Associates and its related entities, agents, contractors, including but not limited to scheduling, billing, marketing and other departments to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including prerecorded messages or text messages) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting Hand Therapy Associates or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Hand Therapy Associates immediately of any change in telephone number or email address.

______________________________ ______________
Patient / Guardian Signature Date

RELEASE OF INFORMATION

I hereby authorized Hand Therapy Associates to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name	Relationship	Phone Number

______________________________ ______________
Patient / Guardian Signature Date

Name: ______________________________

DOB: ______________________________

PATIENT INTAKE
COMMERCIAL INSURANCE

PATIENT HEALTH QUESTIONNAIRE

Occupation: ____________________ Height: ________ Weight: ________ Sex: ☐ Male ☐ Female

Leisure Activities / Hobbies: ______________________________

Are you? ☐ Right-handed ☐ Left-handed

Where do you live? ☐ Private Home ☐ Apartment / Rented Room ☐ Assisted Living / Group Home

☐ Hospice ☐ Other: ______________________________

With whom do you live? ☐ Alone ☐ Spouse Only ☐ Spouse and Others

☐ Child ☐ Other: ______________________________

Does your home have? ☐ Stairs, NO Railing ☐ Stairs, Railing

☐ Ramps ☐ Uneven Terrain

Please Explain: ______________________________

How many times have you fallen in the past 12 months? ________ Did it result in an injury? ☐ Yes ☐ No

Do you have a fear of falling? ☐ Yes ☐ No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

General Health Status ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any known allergies (including medications, latex, etc.) below.

____

SURGERY / HOSPITALIZATION (including date and reason)

______________________________ ______________________________

______________________________ ______________________________

CURRENT MEDICATIONS (including prescription, over the counter, and herbal)

You can also provide our office staff a list to copy.

Name	Dosage	Frequency	Please Indicate Route
			☐ Oral ☐ Patch ☐ Topical ☐ Other: ________
			☐ Oral ☐ Patch ☐ Topical ☐ Other: ________
			☐ Oral ☐ Patch ☐ Topical ☐ Other: ________
			☐ Oral ☐ Patch ☐ Topical ☐ Other: ________
			☐ Oral ☐ Patch ☐ Topical ☐ Other: ________

Name: ______________________

DOB: ______________________

PATIENT INTAKE
COMMERCIAL INSURANCE

CURRENT CONDITION

When did this problem(s) first begin / date of onset? ______________________

If chronic, when did you seek medical treatment? ______________________

Is your condition related to recent surgery? ☐ Yes ☐ No If yes, specify date of surgery: ________

Describe the problem(s). ______________________

Explain how the problem(s) occurred. ______________________

Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times: ________

Are your symptoms worse in: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same All Day

How are you taking care of the problem(s) now? ______________________

What is your current pain level (0 – 10; 0 no pain) ______________________

My pain / problem is slowly getting: ☐ Worse ☐ Better ☐ Staying the Same

My symptoms bother me: ☐ Constantly (100%) ☐ Most of the Time (75%) ☐ Occasionally (50%) ☐ Once in a While (25%)

Do you have any numbness, tingling or burning? ☐ Yes ☐ No

If yes, please check one: ☐ Constantly ☐ Intermittently

What functions could you perform before, that you are now unable to do?

____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.

____

Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.

____

Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No

If yes, please tell us what it is: ______________________

What are you goals for therapy? ______________________

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING

Nausea or Vomiting	☐ Yes	☐ No	Chest Pains (Angina)	☐ Yes	☐ No
Productive/Chronic Cough	☐ Yes	☐ No	Pain Wakes Me at Night	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No	Recent Fever, Chills, Sweats	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Difficulty Sleeping	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Visual Problems	☐ Yes	☐ No	Heart Palpitations	☐ Yes	☐ No
Hearing Loss/Ringing in Ears	☐ Yes	☐ No	Loss of Appetite	☐ Yes	☐ No
Difficulty Walking	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No
Unusual Weakness	☐ Yes	☐ No	Fatigue or Myalgia	☐ Yes	☐ No
Joint Pain or Swelling	☐ Yes	☐ No	Unexplained Weight Changes	☐ Yes	☐ No

Name: ______________________________

DOB: ______________________________

PATIENT INTAKE
COMMERCIAL INSURANCE

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

Condition	Yes	No	Condition	Yes	No
Allergies	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Hepatitis, If Yes, Type:	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Respiratory Problems	☐ Yes	☐ No	Kidney Disease/Problems	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Spinal Cord Stimulator	☐ Yes	☐ No
Bowel or Bladder Disorder	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Cancer, If yes, Site:	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cardiac Conditions	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Parkinson’s	☐ Yes	☐ No
Currently Pregnant	☐ Yes	☐ No	Peripheral Vascular Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Speech Problems	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Auto Immune Disease	☐ Yes	☐ No	Fractures	☐ Yes	☐ No

If yes, Type: ______________________________

SOCIAL HISTORY / WELLNESS

Do you drink alcoholic beverages?	☐ Yes	☐ No	Do you use tobacco?	☐ Yes	☐ No

How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition?

☐ At least 3 times per week ☐ 1-2 times per week ☐ seldom or never

I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

______________________________ ______________________________

Patient / Guardian Signature Date