

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 ☐ 3<sup>rd</sup> 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 ☐ 3<sup>rd</sup> 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: \_\_\_\_\_

## PATIENT INTAKE COMMERCIAL INSURANCE

### 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

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

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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 your goals for therapy? \_\_\_\_\_

### ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING

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

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### HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING

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

### SOCIAL HISTORY / WELLNESS

Do you drink alcoholic beverages?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?					
<input type="checkbox"/> At least 3 times per week		<input type="checkbox"/> 1-2 times per week		<input type="checkbox"/> 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