NEW PATIENT INFORMATION SHEET

NAME:_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____

BILLING ADDRESS: _____

SS#:_____ HOME PHONE#:_____ CELL PHONE #:_____

DOB:_____ AGE:_____ SEX:(M / F) EMAIL:_____

EMPLOYER:_____ WORK PHONE:_____(EXT_____)

MARITAL STATUS: (M – S – D – W) REFERRING PHYSICIAN:_____

MEDICAL PROBLEM:_____ DATE OF INJURY (IF APPLICABLE):_____

STUDENT: (YES / NO), If yes: (PART TIME / FULL TIME) SCHOOL: _____

AUTO ACCIDENT: (YES / NO), If yes: DATE OF INJURY / ACCIDENT:_____

WORK INJURY: (YES / NO) WORKERS COMPENSATION REPORTED: (YES / NO)

EMERGENCY CONTACT :_____ PHONE #:_____

INSURANCE: PRIMARY_____ SECONDARY_____

Are you a Blue Cross Blue Shield Blue Advantage policy holder? If YES, please notify the front desk.

Are you the policy holder? (YES / NO)
If NO, fill out section below:

Are you a minor? (YES / NO)
If YES, fill out section below:

POLICY HOLDER/GUARDIAN INFORMATION:

NAME:_____
(LAST) (FIRST) (MIDDLE)

Date of Birth:_____

Address:_____

CITY:_____ STATE:_____ ZIP: _____

AUTHORIZATION FOR TREATMENT / RELEASE OF INFORMATION I hereby authorize Texas Hand Therapy to release all information acquired in the course of my medical treatment or the treatment of my child to the referring physician, insurance carriers, and/or to the health care financing administration and it's agents. I hereby authorize payment of all medical benefits to Texas Hand Therapy for services received at this office, including Medicare benefits. I have read the financial policy of Texas Hand Therapy understand it, signed it and accept complete responsibility or full payment of my medical expenses not compensated by my health insurance carrier.

PATIENT / RESPONSIBLE PARTY / GUARDIAN SIGNATURE:

X_____ DATE_____

A photocopy of this authorization and assignment shall be considered as valid as original.

PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you

MEDICAL HISTORY: (please check any condition you have a history of. Items not checked are understood to be negative.)

___ Alzheimer's
___ Cardiovascular Disease
___ Cauda Equina Syndrome
___ Cerebral Vascular Accident
___ Current Infection
___ Diabetes Mellitus Type 1
___ Diabetes Mellitus Type 2
___ Fibromyalgia
___ Fracture or Suspected Fracture
___ High Blood Pressure
___ History of Cancer
___ Huntington's
___ Immunosuppression
___ Lupus
___ Muscular Dystrophy
___ Obesity
___ Osteoarthritis
___ Osteoporosis
___ Parkinson's
___ Rheumatoid Arthritis
___ Seizures / Epilepsy
___ Traumatic Brain Injury

Other? _____
_____
_____
_____

Do you have a history of fractures? YES NO Where?_____
Do you have any metal implants? YES NO Where? _____
Do you smoke? YES NO How much per day?_____
Do you exercise regularly? YES NO How often?_____
Do you have any known allergies? YES NO Please list_____
Are you allergic to latex? YES NO
Are you pregnant or suspect pregnancy? YES NO

PAIN SCALE: For each item below rate your pain on a scale of 0 (no pain) – 10 (extreme pain)
At worst: _____ Current: _____ At best: _____

MEDICATIONS: Please list names of current medications (or provide list to receptionist to copy)

_____
_____
_____
_____

SURGERIES: Please list surgeries pertaining to your current problem area, including date:

_____

DIAGNOSTIC TESTS: Please check test(s) for current problem only.

( )X-rays ( )CT scan ( )MRI ( )Bone Scan ( )EMG ( )Bone Density
( )Ultrasound ( )Other (please specify) _____

Signature_____ Date:_____

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

CONSENT TO TREATMENT RECORD

Initial Below

	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by Texas Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Texas Hand Therapy may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Texas Hand Therapy for services rendered. ➢ I agree that Texas Hand Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to *Texas Hand Therapy* for services rendered.
	Patient Agreement ➢ I agree to pay *Texas Hand Therapy* charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay *Texas Hand Therapy* collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to *Texas Hand Therapy* in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that *Texas Hand Therapy* may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to *Texas Hand Therapy* in applying for benefits under Workers Compensation is complete and accurate. I agree that *Texas Hand Therapy* may give intermediary's information necessary to process claims.
	Patient Attendance ➢ I agree with the attendance policy as stated in Texas Hand Therapy's Policy and Procedure Manual and stated below: If a patient cannot keep a scheduled appointment, the patient/family is responsible for calling and canceling the appointment prior to the scheduled appointment time, and attempt to reschedule. If the patient fails to give notice, we will be reinforcing the **$50 "no-show" fee. The patient will be responsible for this fee as insurance will not cover it.** If a patient arrives late for a scheduled appointment, he or she may not be able to receive their full treatment that day and are not guaranteed to receive a treatment if more than 20 minutes late.

Patient Signature Witness Signature Date

PAYMENT ARRANGEMENT

Insurance Breakdown:

- If your insurance plan includes a deductible, you will be responsible for the entire allowed cost of each therapy visit until that deductible is met.
- Once your deductible has been met (or if you do not have a deductible), you will be responsible for the coinsurance percentage that is specific to your insurance plan.
- If your insurance plan includes a copay for in office Occupational Therapy, you will be responsible for payment of that copay at each appointment.

Billing:

- You are welcome to check your balance with the front desk at any time. You may also pay this balance in office by means of card, check, or cash.
- In addition, you will receive a bill statement with therapy charges once your insurance carrier has processed these charges.
- Our billing is handled by Marway Business Services. If you have any questions regarding your bill, you may also contact Marway at 979-774-6633.

If you have any questions regarding insurance and/or billing, do not hesitate to let Texas Hand Therapy and/or your insurance carrier know.

By signing below I am agreeing that I have read and understand the above. I am agreeing to the terms in which I may be billed from Texas Hand Therapy.

_____

Print your name

_____ *Date:* _____

Sign your name