Last Name: _____ First Name: _____

Address:_____City:_____
State:_____ Zip Code: _____ Male: _____ Female: _____

Status: Minor Single Married Other

Email Address: _____

Opt In to email statements YES_____ NO_____

Social Security Number: _____-_____-_____

Primary Phone: _____ Home Cell Work

Secondary Phone: _____ Home Cell Work

Date of Birth : _____/_____/_____ Age: _____

Height: _____ Weight: _____

Employer: _____ Phone: _____

Job Title: _____

Spouse/Parent Name: _____ Relationship: _____

Employer of Spouse/Parent: _____

Emergency Contact: _____ Phone: _____

Relationship to Emergency Contact: _____

GENERAL HEALTH INFORMATION:

Are you currently working? Y or N Do you have restrictions? Y or N

Name of referring Physician: _____

Name of general Physician: _____

Last known Blood Pressure: _____

Do you have an infectious disease? _____

Please explain how this injury occurred:

_____

_____

Is this injury related to any of the following? (circle one) Sports Auto Work Other

Which body part was injured? Right___ Left___ Bi-lateral___

Injured area? _____

Original Date of Injury: _____ Did you have Surgery? Y or N

If yes, please list surgery date: _____

Rate your CURRENT pain level from one to ten 1 2 3 4 5 6 7 8 9 10

Please list any medications that you are taking (related to this injury):

_____

INSURANCE INFORMATION:

Did this injury occur at work? Y or N

If, Yes, Name of Company: _____

Insurance Carrier: _____

Insured's Full Name: _____

Male: ____ Female: ____Insured's Date of Birth: ____/_____/_____

Relationship to Insured: _____

ID Number: _____ Group Number: _____

Have you received ANY other type of therapy at another facility this year? Y or N

If yes, please list facility: _____

Do you have an attorney for this injury? Y or N

If yes, Name of Attorney/Firm: _____

Responsibility and Consent Statement

Patient Name: _____

I consent to rehabilitation and related services at Advanced Hand Therapy. If applicable, I certify that I am the guardian of the minor being treated.

I consent to the disclosure of my protected health information by Advanced Hand Therapy for the purpose of providing my treatment, obtaining payment for my healthcare bills, or to conduct healthcare operations.

Patient agrees to pay for all portions of services, due in full at the time of services are provided by our office.

The patient is responsible for providing ALL insurance information. If the patient does not provide information at the time of service the patient will be considered SELF PAY until all correct information is received.

Commercial Insurance Carriers: We bill most insurance carriers. The patient is responsible for providing all the needed information such as, the carrier and policy or ID number for the policy to the office staff. If for whatever reason, the insurance company(s) do not pay for the services provided then the patient assumes all responsibility and agrees to pay the amount owed in full.

Medicaid/Medicare: Our office is a participating provider, and we will submit claims.

Workman's Compensation: If your visit is work related you are responsible for providing the case number and carrier prior to your visit so we can bill the correct carrier.

Advanced Hand Therapy has no responsibility in the decision the patients' insurance company makes. If the patient has any questions or concerns pertaining to the insurance decisions or amount, it is up to the patient to contact their insurance company's customer service.

Methods of Payment: Our office accepts cash, personal check, and debit/credit cards. We also offer patient financing. For returned checks we assess a $50.00 NSF fee. If returned check is not paid within two weeks of the return date checks will be reported to the local district attorney's office. A 5% charge will be added to any unpaid balance each month after 90 days.

To ensure we can provide the highest level of care to all patients, we require 24-hour notice for any appointment changes or cancellations. Appointments that are cancelled or rescheduled without proper notice are subject to a $50.00 fee per 30 minutes of reserved appointment time.

Repeated missed appointments – defined as three or more late cancellations or no-shows – may result in removal from the treatment plan at Advanced Hand Therapy.

Patient Signature: _____ Date: _____