DESERT HAND THERAPY
PATIENT REGISTRATION AND CONSENT FORMS

Today's Date: ________ Office Location: ______ Therapist: _________

PATIENT INFORMATION

Patient First Name _______________________________ Last Name _______________________________ MI__________

Address____ Apartment #_____________

City ____________________________________ _____________ State_____________ Zip Code ____________________

Home Phone __________________________ Cell Phone________________________ Work Phone____________________

Place of Employment ____ Type of Occupation ________________________

Date of Birth ___________ Age___ SS#______________________ EmergencyContact______________Phone____________

Sex: ___Male ___Female Marital Status: ___Single ___Married ___Divorced ___Widowed Student Status: __________

RESPONSIBLE PARTY

First and Last name of **Insured Responsible Party** _______________________________________ Date of Birth __________

Address ____ Apartment # _____________________

City ____________________________________ ___ State ____________________ Zip Code _______________________

Cell Phone # ______________________________________ Home Phone# ___________________________________

Employer Name____ Employer Phone# ________________________

Relationship to responsible party ______________________________

INJURY INFORMATION

Referring Physician____ Phone # __________________________________

Primary Care Physician ____ Phone #___________________________________

Date of injury_____________________ Injured Area/Body Part____

Side Affected **Right** **Left** Are you Right or Left handed? _____________ DID YOU HAVE SURGERY? YES NO

If yes, date of surgery ______________ **Explain nature of the accident or injury**__________________________________

____

Accident related: Auto___ Work___ Other___ Explain other ____

OTHER INFORMATION

Are you currently enrolled or applying for AHCCCS? Yes___ No___

Is your Medicare Registered in the state of Arizona? Yes No

If No, What state is your Medicare registered? ________________________

PERMANENT ADDRESS

Same as above? Yes No

If not, address ____ Apartment # ____________

City ________________________________ State _________________ Zip Code _______________

Are you enrolled in a hospice, home health agency or a skilled nursing facility? Yes ___ No___

If yes, facility name ____________________________________ Phone # ___________________

***Are you receiving or have recently received other therapy services?** Yes___ No___

If yes, when ____

INSURANCE INFORMATION

PRIMARY Insurance name_________________________________**Phone#**________________

ID# ____ Group # _______________________

Insurance billing address ____

Policy Holder's first and last name _____________________________ Date of birth ______________

Social Security number of insured party_______________________ Insured party's sex: M ___ F___

Employer name of insured party ______________________________ Phone #________________

Relationship to patient ____

SECONDARY Insurance name______________________________ **Phone#**____________________

ID# ____ Group# ______________________________

Insurance Billing address ____

Policy Holder's first and last name ______________________________ Date of birth________________

Social Security number of insured party _________________________ Insured party's sex: M ___ F ___

Employer name of insured party___________________________________ Phone# ________________

Relationship to patient ____

<u>WORKMAN'S COMPENSATION INFORMATION</u>

Insurance Carrier name_________________________________ Phone# ______________________

Employer name at the time of injury_________________________ Employer Ph#_________________

Claim # _________________ Adjuster or Case Manager's Name ______________________________

Insurance Disclaimer Notice

All insurance(s) information, not limited to primary or secondary, must be disclosed at the initial visit. Failure to give complete and accurate information may result in non-covered service and/or non-billed claim filed to your insurance company due to claim filing limitations and authorization for services. I have read and understand this information; all information above is true and accurate.

Signature____ Date _______________________

CONSENTS

Please Initial

CONSENT TO TREATMENT: I consent to rehabilitation and related services at DESERT HAND THERAPY. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. ____________

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. ____________

LIABILITY: I know and agree that DESERT HAND THERAPY is not responsible for loss or damage to personal valuables. ____________

WAIVER AND RELEASE: I hereby release, discharge and acquit DESERT HAND THERAPY, it's agent's, representatives, Affiliate's, employees, or assigns, of and from any and liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. ____________

AUTHORIZATION OF PAYMENT: I herby sign all benefits directly to DESERT HAND THERAPY and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that I in the event of my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. If my account is sent to a collection agency I understand I will be charged an additional 30% of my balance due, or collection fees. ____________

NOTICE OF PRIVACY: I have been directed to read our Notice of Privacy Practices ____________

BENEFIT RELEASE AND SIGNATURE:
I understand that explanation of coverage will be obtained from my insurance company as a courtesy and it's not a guarantee of coverage. I do not hold DESERT HAND THERAPY and/or its affiliates responsible for any incorrect or omitted or for any charges in my future coverage. If coverage is not a direct contract or if the information provided by my insurance company is not accurate or the insurance company changes its coverage, I agree I will be fully responsible for payment for services. I understand that I can verify this information by reading my insurance book or contacting my insurance company.

Patient/Guardian Signature__________________________________ Witness Signature_________________

IMPORTANT SPLINT INFORMATION
At DESERT HAND THERAPY we make splints that are fabricated and molded to specifically fit you. The splints we make are made for you and your condition per your doctor's orders. Because the splint is custom made there are **no returns or reimbursements** as they cannot be used for anyone else. CHARGES FOR SPLINT(S) MAYBE APPLIED TO YOUR DEDUCTIBLE. Prefabricated (non-custom made) have a 7-day return policy. The prefabricated splint must be returned with the original packaging. Replacement splints (lost, stolen, or destroyed) will be the patient's responsibility to cover the cost of replacing the splint. I have read and understand the splint disclaimer.

Patient/Guardian Signature_________________________________WitnessSignature_________________