

**DESERT HAND THERAPY
PATIENT REGISTRATION AND CONSENT FORM**

Internal Use Only

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# _____ Emergency Contact _____ Phone _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

RESPONSIBLE PARTY

First and Last name of Insured Responsible Party _____

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

Are you enrolled in Hospice or a skilled nursing facility? Yes No If yes, where _____

Are you receiving or have recently received other therapy services including home health? Yes No If yes WHEN, _____

MEDICAL HISTORY

PATIENT NAME: _____ Date: _____

Date of injury/ onset: _____ Date of surgery: _____

How did your injury happen? _____

Are you Right or Left handed? RT LT Are you currently working? Yes No

Reason for attending therapy: (circle all that apply)

Motion Weakness Pain: 0 1 2 3 4 5 6 7 8 9 10

What specific activities are most difficult because of your problem?

1. _____

2. _____

Describe your health: (circle one) Excellent Good Fair Poor

Do you use tobacco: (circle one) Yes No How much? _____

Current Medications: _____

Allergies: _____

Are you allergic to Latex? Yes No

Any previous injuries to this extremity? _____

Have you ever had any of the following conditions? (circle all that apply)

Anemia	Depression	Hepatitis/HIV	Currently Pregnant	Stroke
Asthma	Seizures	Kidney problems	Dizziness/ Fainting	Tuberculosis
Cancer	Fractures	Substance Abuse	Low blood pressure	Epilepsy
Headaches	Diabetes	Metal Implants	High blood pressure(controlled? Yes No)	
Pacemaker	Osteoporosis	Cardiac problems	Rheumatoid arthritis	Osteoarthritis
Thyroid problems		Multiple Sclerosis	Respiratory problems	Insomnia

Any other medical problems? _____

The above information is accurate to my knowledge: _____

NATURE OF TREATMENT

The nature of your treatment, the risks, the possible interventional alternatives and treatment goals have been discussed with you. Also, your medical history has been reviewed by the therapist to assist them in your evaluation and assessment.

Patient signature: _____ Date: _____ Therapists Initials _____

INSURANCE INFORMATION

PRIMARY INSURANCE

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

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 _____

TERTIARY Insurance Name _____ Phone # _____

WORKMAN'S COMPENSATION INFORMATION

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, secondary or tertiary, must be disclosed at the initial visit. Failure to give complete and accurate information may result in non-covered services and/or non-billed claims filed to your insurance company due to claim filing limitations and authorization for services. I have read and understand this information and 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 so doing, 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 hereby 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, for collection fees. _____

NOTICE OR 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 it's 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 it's 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 _____