Hand to Shoulder Rehab, Inc.

New Patient – Medical History and Disclaimer (5 pages)

Name: _____ Age: ___ M__ F__ Other_____ Height: _____ Weight: _____

Referring DR: _____ Next MD visit: _____ Diagnosis:_____

Date of Injury: _____ Date of Surgery: _____ Name of Primary Care physician: _____

What is your Main Complaint? _____

List **all** current Medication and Dosage: *Use the attached sheet*

List **any** Allergies: (cortisone, Latex, iodine, Sulphur etc.)

Please answer all the following questions. If you answer YES **to any, please explain.**

Have you had **X-rays**, **MRI** or other imaging studies for current condition?	**YES**	**NO**	Date or last image:
Have you had therapy or chiropractic care this year?	**YES**	**NO**	Date: # of Visits:
Do you **have** or have you **had** a tumor/growth?	**YES**	**NO**	
Are you sensitive to heat or ice?	**YES**	**NO**	
Do you use Tobacco?	**YES**	**NO**	How Much?
Do you feel you are being maltreated by a caregiver, family member or other?	**YES**	**NO**	
Was this injury caused by a fall?	**YES**	**NO**	
*How many falls have you had in the last 12 months?			
Do you currently receive Home Health?	**YES**	**NO**	Specify PT or OT

How many standard size alcoholic drinks do you drink per week: Per Occasion:

Do you feel you are being maltreated by a caregiver, family member or other?

Check **all** the symptoms you are **CURRENTLY** experiencing:

☐ Fever/Chills/Sweats	☐ Diarrhea	☐ Numbness or Tingling
☐ Nausea/Vomiting	☐ Unexplained weight loss	☐ Poor Balance/Falls
☐ Dizziness	☐ Fatigue	☐ Depression/Anxiety/Helplessness
☐ Fainting Spells	☐ Shortness of Breath	☐ Pregnancy

Check **all PAST** and **PRESENT** conditions:

☐ High Blood Pressure	☐ Diabetes	☐ Respiratory/Breathing Problem
☐ Stroke	☐ Circulation/Bleeding Problems	☐ Lung Disease
☐ Cholesterol	☐ Blood Disorders (hepatitis or	☐ Emotional/Psychological Px
☐ Heart Conditions	other_____)	☐ Insomnia/Nightmares
☐ Pacemaker	☐ Infectious Disease	☐ Hearing Loss
☐ Arthritis	☐ Kidney Disease	☐ Other serious medical
☐ Osteoporosis	☐ Liver Disease	condition we should know:
☐Osteoarthritis/Rheumatoid arthritis	☐ Lupus/Scleroderma/fibromyalgia	_____
☐ Cancer	☐ other autoimmune disorders	

How do you rate your General Health? **Excellent** **Good** **Fair** **Poor**

What are **YOUR** goals for therapy? Also briefly describe your job. Please include lift, carry, push, pull:

MEDICATION LIST

Medication Name:	**Dosage:**	**Frequency:**	**Route of Administration:**
(Includes prescribed, over-the-counter, herbal, and vitamin/mineral/ dietary supplements)			*(Ex: Oral, Injected, topical…)*

Hand to Shoulder Rehab, Inc.

New Patient – Medical History and Disclaimer (5 pages)

Patient Disclaimer (pg. 1 of 3)
We are committed to serving you in the best possible way. In order to achieve this goal, we ask that you please read the following terms for receiving care in our facility.

There will be a $50.00 charge for "no shows", same day cancellations, *and returned checks*. Absolutely no exceptions.

Worker's Comp Patients: Please extend the courtesy of calling us for any cancellations the day before your scheduled appointment. We are required to notify your insurance company and doctor of cancellations or missed appointments and note it in your chart. Frequent cancellations or "no shows" may jeopardize your claim.

We have several therapists: working here that have varying weekly shifts; it is probable that you will see more than one therapist during your course of treatment. Even so, it is our goal to give consistent care. For any special accommodation, please let us know and we will do our best to meet your request.

Claims Filing, Co-Pays/Co-Insurance: We file insurance claims as a courtesy to our patients. The patient is ultimately responsible, however, from the date the services are first rendered. Any co-pay/co-insurance required by your insurance plan will be due at the time that services are rendered. Monthly statements will be sent for but all balances on account remain the responsibility of the patient. Delinquent accounts are sent to collections.

I agree to assign all medical payments for this clinic's services, including private insurance and any other health plans to Hand to Shoulder Rehab, Inc. I understand and agree that I am ultimately responsible for all charges for services & supplies rendered.
I will notify you of any changes in insurance coverage.

Not all Insurance Companies Cover Supplies: Please note that your therapy may call for such items as splints and exercise equipment that may not be covered; If your insurance company does not cover items given, you will be required to pay for them at the time service is rendered.

Private Pay Patients: Our fees are usual and customary. These rates will be discussed based upon the determined treatment plan. Payment of services is due at the time the services are rendered, unless other arrangements have been approved. Supplies such as splints, exercise equipment, must be paid for on the date of service.

Supervising Children: Please carefully supervise your children while in the clinic. *They should not play with any equipment*. Hand to Shoulder Rehab, Inc. will assume no liability for any injuries to children or other visitors playing in the clinic.

BY SIGNING THIS DOCUMET, I CERTIFY THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE TERMS AND POLICIES WRITTEN HEREIN.
Patient's Name: _____ Signature: _____ Date: _____

Patient Disclaimer (pg. 2 of 3)
Medicare Patients Only

NOTE: Are you a current or intermittent patient of Home Health or in a Skilled Nursing Facility? **If yes**, you are not eligible to be seen in outpatient therapy at this time. These services must be stopped before pursuing Outpatient services as Medicare does not cover both. *Please see the receptionist.*

Please inform us if Medicare is primary or secondary and please produce ALL insurance coverage at time of service.

Medicare has implemented a fixed annual budget for Occupational Therapy services and a separate amount for Physical Therapy services per year. This equals approximately 18-22 visits for each discipline per year.

Once the benefits have been exhausted, you do have an option of receiving additional services at an outpatient hospital-based clinic, if it is deemed medically necessary, or pay cash. See the front desk for self-pay rates.

This clinic does its best to monitor the number of treatment visits you have to help you know when the budget is close to being reached, or has been reached. I understand, however, that it is my responsibility to check on my balance remaining, directly with Medicare.

I understand and agree that I am ultimately responsible to pay for any services I receive in excess of the Medicare budget which is based on medical necessity and NOT dependent on the number of procedures or incidences in a year. This budget will reset in the January of each year.

Please inform us if you have signed up for a Medicare Prescription Drug Plan as services may not be covered at our clinic, if you are enrolled in ***Kaiser Medicare*** inform the receptionist immediately before any services are rendered.

If you are receiving *Home Health or Skilled nursing OT or PT at this time you are not eligible to receive out-patient OT or PT services.* You must complete or stop the services before coming for outpatient services. If you choose to do the service you will be a self-pay patient as Medicare does not cover both.
Medicare does have a max dollar value for Occupational Therapy (OT) & Physical Therapy (PT).
Have you received either OT/PT services in current calendar year? **Circle: Yes ◯ NO ◯**

If **YES,** how many Visits have you received _____?

BY SIGNING THIS DOCUMET, I CERTIFY THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE TERMS AND POLICIES WRITTEN HEREIN.
Patient's Name: _____ Signature: _____ Date: _____

Patient Disclaimer (pg. 3 of 3)

1. I have read and received a copy of the Privacy HIPPA Policy. I acknowledge receiving a copy of the Privacy HIPPA Policy and give my consent to release my PHI. (Protected Health Information) If filling this out online, please download and keep a copy for your reference.

   Patient Signature: _____ **Date:** _____

   If you are represented by an Attorney, please provide the Law Office information: _____
   _____

2. I have read and received a copy of the Patient Disclaimer showing the company policy. This includes, No show/ Same day Cancellation fee of $50.00

   Patient Signature: _____**Date:** _____