SUMMIT HAND THERAPY

Patient Name: _____ Date of Birth: _____/_____/_____ Phone: (_____)_____

Mailing Address:_____ Apt #:_____ City:_____State:_____ Zip:_____

Social Security:_____ Email:_____Sex: M or F

Employer's Name: _____ Employer's Phone: (_____)_____

In case of emergency contact: _____ Phone: (_____)_____

Responsible Party (If Minor)

Responsible Party Name: _____ Phone: (_____)_____

Mailing Address: _____Apt #: _____ City: _____State: _____ Zip: _____

Social Security: _____ Date of Birth:_____/_____/_____ Email:_____

Medical Information

Doctor's Name who referred you to our office: _____ Phone: (_____)_____

Primary Care Physician's Name:_____ Phone: (_____)_____

Have you ever been treated at Summit Hand Therapy before? (circle one) Yes or No

What side of the hand/arm is involved? (circle one) Right or Left or Both *Your handedness: Right or Left*

Date of Injury: _____ Is the injury related to an accident at: (circle one) Work / Home / Automobile / Other

Did you have surgery? Yes or No Surgery Date: _____/_____/_____

Explain the accident details: _____

Have you had cardiovascular/pulmonary rehab, physical, occupational, chiropractic, or speech therapy this year?
Yes / No

Are you currently enrolled in one of the following; Skilled nursing facility, Home health Agency, or Hospice care?
Yes or No

***If so, complete the following information: Name of facility:* _____

Address: _____Phone: (_____)_____

Insurance Information

Primary Insurance: _____ Policy #: _____

Policy Holder's Name: _____ Policy Group #: _____

Secondary Insurance: _____ Policy #: _____

Policy Holder's Name: _____ Policy Group #: _____

Please complete below if this is an industrial/work- related injury:

Employer at time of injury: _____Phone: (_____)_____

Insurance Name: _____ Claim Number: _____ Adjuster Name: _____

Adjuster Phone: _____Adjuster Fax/Email:_____

Signature: _____ Date: _____/_____/_____

PATIENT:_____ DOB:_____

Financial and Consent for Treatment document

Notice of Privacy Practices

I acknowledge that I have been provided a copy of the Summit Hand Therapy's copy of the Notice of Privacy Practices for the Protected Health Information according to HIPPA regulations. A copy of the notice is found in the patient waiting area and at the front desk.

Consent for Treatment

I consent to the medical treatments, services and procedures to be performed by the Summit Hand Therapy employees including therapy aides, staff and state licensed Occupational therapists. The therapy will be performed on an outpatient basis. Such treatments will be determined by the therapist and a plan of care will be set between the therapist and the referring doctor. Because every injury and diagnosis is different, Summit Hand Therapy cannot be held responsible for injury or damage to an injury due to healing issues or poor surgical repair beyond our control. Summit Hand Therapy and staff will not be held responsible for loss of or damage to items brought by the patient into our facility.

Financial Agreement

I agree that in return for the services provided by Summit Hand Therapy, I will pay the account of the patient and/or prior to discharge from therapy make financial arrangements satisfactory to Summit Hand Therapy and /or other providers for payment. It is Summit Hand Therapy's policy to require payment of all office copayments, deposits or payments required for products or services at the time of service, unless prior arrangements have been made. All accounts over 60 days will be charged an interest rate of 1.5% per month (18% per annum) or $1.00 minimum, which I agree to pay. Additionally, a billing fee of $10.00 will be assessed for all accounts over 60 days past due and for any missed copayments. In the event any balance due hereunder is not paid as agreed, I jointly and severally agree to pay all costs charged by the collection agency, legal fees and court costs. I further agree to pay an additional amount of up to 33.3% of the principal balance if the account is referred to a collection agency. This additional amount is in recognition of costs associated with said collection action processing. If an account is sent to any attorney for collection, I agree to pay attorney fees and costs with or without suit, incurred in collecting any past due balance, and collection fee if my account is assigned to a collection agency. I request that payment of any authorized Medicare benefits be made on my behalf. I assign the benefits payable for therapy services to the therapists and or the organization furnishing the services or authorize such therapist and Summit Hand Therapy to submit a claim to Medicare or my insurance covering my services. I am aware of the therapy benefits my policy offers and will pay for any charges my insurance does not pay.

Services under a Lien

If any services are performed that are ultimately the responsibility of a third party (i.e., patient is pursuing a personal injury claim) or performed at the direction of an attorney, either at the beginning or during the course of therapy, the patient will be required to sign a lien with Summit Hand Therapy and will be required to pay the charges for the course of treatment in full, with no reductions or obligations on the part of Summit Hand Therapy to bill insurance of any kind. Payment shall be made within 45 days following the resolution of the patient's claims by settlement, arbitration, trial, or other dispute resolution process.

I have read and understand the financial agreement, consent for treatment, and the services covered under a lien above. I understand that as the undersigned I am primarily and ultimately responsible for the payment of the patient's bill. I understand that I am responsible for all deductibles and charges not covered by insurance.

_____

Signature of Patient, Parent/ Guardian or Legal representative **Today's Date**