ADVANCED HAND & ORTHOPEDICS
NEW PATIENT INFORMATION

Patient_____Social Security #_____

Address_____Phone(H) _____

City_____State_____Zip_____(W)_____

Physical Address_____(Cell)_____

Birth Date_____Age_____Sex_____ May we leave a message by phone? Yes____No _____

Employer_____Occupation_____

Address _____City_____State_____Zip_____

Date of Injury_____Date of surgery_____Work Injury? Yes___No___

Allergy/Medical History_____

Physician Name_____

****

Emergency Contact

Name_____Birth Date_____Relationship:_____

Contact Information:_____

****

INSURANCE INFORMATION

Name of Insured_____SSN_____Birth Date_____

Address_____

Insurance company_____Address_____

ID #_____Group#_____Claim#_____

****

I,_____, authorize medical benefits to be paid directly to Advanced Hand & Orthopedics. I, acknowledge that I am financially responsible for the non-covered services and my bill in full, at the rates which are set forth in the company invoices, regardless of insurance coverage. I further authorize the release of any medical information necessary to process an insurance claim on my behalf. *Advanced Hand & Orthopedics will only use your personal information for purposes of treatment, payment, or health care operations in accordance with the Health Insurance Portability and Accountability Act (HIPPA). If there are any questions on how your personal information will be used, ask to see our Notice of Privacy Practices. You have the right to request restrictions and revoke consent in writing after you have reviewed our privacy notice. A photostatic, xerox, telefax, or other conformed copy of this agreement is as valid as the original.

Have you contacted your insurance company in regard to Out Patient Occupational therapy benefits? Yes___NO___

Do you have an authorization number for treatment? Yes ___ No ____

Patient/Guardian Signature_____Date_____

I plan to pay for today's visit by CHECK_____CASH_____CC_____

*** Have you been seen by another Therapist this year (PT,OT,ST,MT)? Yes____No_____**

ADVANCED HAND & ORTHOPEDICS

CLIENT INTAKE FORM

Name: _____ Date: _____
Hand Dominance: □ Right □ Left Age: _____

How did you hear about our services? □ Doctor □ Nurse practitioner/PA □ Chiropractor □ Friend/family
□ Internet □ Other: _____
*Your email address: _____(optional)
Your email is used share information about your diagnosis, healthy life style tips, and monthly newsletters …

WORK INFORMATION
Are you currently employed? □ Yes □ No
What is your job title/position? _____

What are your job duties/responsibilities? _____
_____

What is your work status? □ Full-duty □ Full-time □ Part-time □ Restrictions □ Retired
□ Light-duty □ One-handed □ Off-duty □ Disability □ Student

PAST MEDICAL HISTORY
Please circle any past or current medical problems you may have:

Cardiac Heart Failure	Cancer	Stroke	Thyroid
Pacemaker	High Blood Pressure	Head Injury	Seizure
Cardiovascular Disease	Diabetes	Neck or Back pain	Parkinson
COPD	Gout	Rheumatoid Arthritis	Auto-immune Disease
Irregular Heart rate	Arthritis		

Other (please list): _____

Please check if you are a □ non-smoker □ smoker.

Have you fallen in the last 6 months? □ Yes □ No

Please list any previous neck, shoulder, arm, and/or hand surgeries and/or injuries:_____
_____

Do you have any metal implants or artificial joints? □ Yes □ No

Do you have any allergies? Please specify: _____

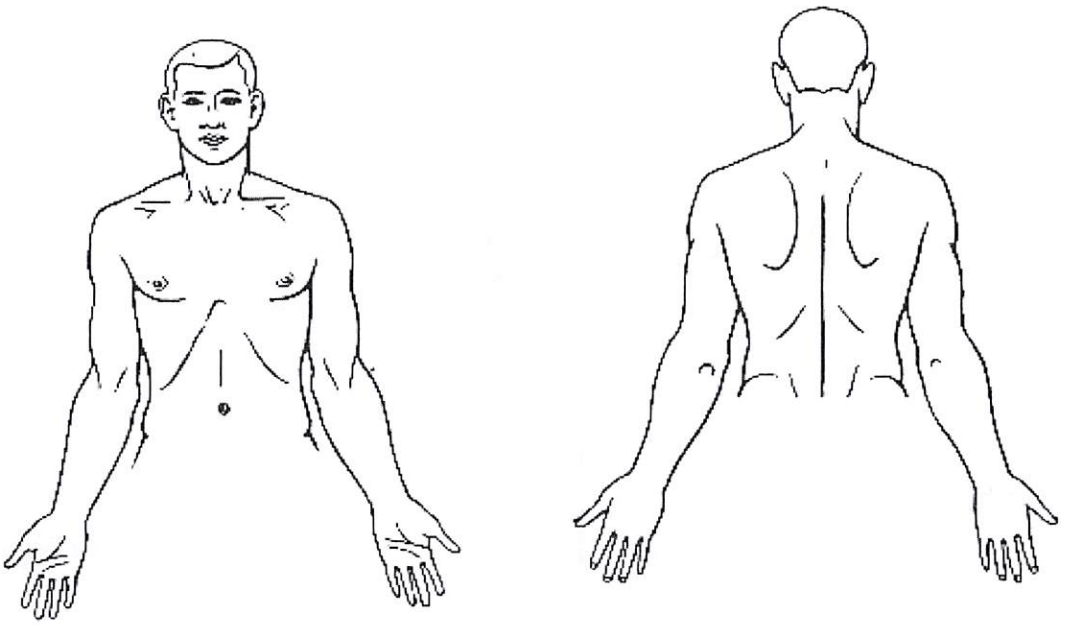
Are you taking any medications? Please list: _____
_____

Have you had any of the following tests performed for your current problem:

Test			***Results:***
X-rays	□ Yes	□ No	_____
Nerve conduction test	□ Yes	□ No	_____
EMG	□ Yes	□ No	_____
CT Scan	□ Yes	□ No	_____
MRI	□ Yes	□ No	_____

SYMPTOMS

Please use this diagram to **circle** any problem areas:



PAIN

On a scale of 0 – 10, circle the number that best describes the intensity of your worst pain in the last week.
0 = no pain, to 10 = worst pain you could imagine.

0 1 2 3 4 5 6 7 8 9 10

TELL US ABOUT YOUR CURRENT CONDITION…

Date of injury: _____

Date of surgery: _____

What happened? Briefly describe your current problem/symptoms: _____

_____

Have you ever had these symptoms before? When? _____

Previous treatment for this problem? _____

What makes it better? _____

What makes it worse? _____

Have you tried any devices or orthoses? _____

How does this impact your life? What can't you do as a result? _____

_____

What hobbies/recreational activities do you enjoy? Are you having any difficulties performing these activities?

_____

What are your goals in coming to therapy? _____

_____

* Did you need any help filling out this form_____

Advanced Hand & Orthopedics

FINANCIAL POLICIES

We have prepared this document to help answer many of the questions patients have with regard to the financial policies of Advanced Hand & Orthopedics. Although it appears quite lengthy, we would appreciate you reading the information and then signing in the space provided at the end. Please ask any further questions.

New Patients

Charges for a patients first visit must be paid in full with cash, check, or credit card (Visa/Mastercard). If you have insurance, we will prepare the insurance form for you and submit it to the insurance company for reimbursement directly to you. On subsequent visits, you need only pay the estimated uninsured portion of the incurred charges. You, as the guarantor, are the person responsible for payment of the account. If you have overpaid the estimated amount we will refund the money within 30 days of the last transaction.

Continuing Patients

A. PATIENTS WITH INSURANCE

SINGLE POLICY COVERAGE--The estimated uninsured portion of your incurred charges (the co-payment or deductible amount) is to be paid for at the end of each appointment unless prior arrangements have been made. We will prepare an insurance claim form at the end of each week and submit it to your insurance company requesting payment made directly to our office. If we fail to receive payment from your insurance company within 60 days of the submittal date, the total amount in question is due and payable by you at that time. Interest charges will begin to accrue on all balances that are 30 days or older at a rate of 1.25% per month which equals 15% per year.

MULTIPLE POLICY COVERAGE--For those patients with multiple coverage, the co-payment amount is to be paid as above, except that this will generally apply only to the insurance deductible specific to each policy. The 60 day limitation described above will apply to all insurance claims made on your behalf. We will only bill 2 insurance companies.

ULTIMATE RESPONSIBILITY--You are ultimately responsible for the payment of any outstanding charges on your account, **regardless of your insurance coverage.** Unpaid accounts will be subject to our *Delinquent Accounts* policy stipulated below.

B. PATIENTS WITHOUT INSURANCE

All charges incurred at the time of service must be paid for in full at the end of each appointment unless prior arrangements have been made. The term co-payment applies to you in the paragraphs that follow in the sense that insurance payments are not expected, so the co-payment amount is the actual charges incurred. Interest rate at the rate of 1.25% per month will accrue on balances 30 days of more past due. Unpaid accounts will be subject to our *Delinquent Accounts* policy as stipulated below.

Medicare, Medicaid and Others

Certain items that may benefit you in therapy are considered nonessential items and are not covered, i.e. custom or prefabricated splints, putty, gripper, theraband, etc. If these items are suggested for your benefit and are necessary for your treatment you are responsible for payment.

Workers Comp. Claims

All state workers compensation laws will be complied with by Advanced Hand & Orthopedics. As long as there is an open claim injured workers are not responsible for their medical bills. On a controversion claim, Advanced Hand & Orthopedics will bill private insurance or accept payments unless other arrangements have been made prior to treatment.

NSF Checks and checks drawn on closed bank accounts

If a check is returned unpaid to our office from your bank due to non-sufficient funds, we will contact you by telephone and advise you as such. We will resubmit the check **one time only** and if it is returned unpaid the second time a $25.00 NSF charge will be added to your account.

If a check is returned to our office from your bank due to a closed account, a $25.00 NSF charge will immediately be added to your account balance.

DELINQUENT ACCOUNTS

A statement of your account will be mailed to you at the beginning of each month if an outstanding balance exists, collection will proceed as follows. If, due to unknown circumstances you are unable to pay your account in a timely manner prior to collection activity commencing, please contact our office to make arrangements for payment.

****All accounts are subject to a $25.00 service fee and when the account is determined to be delinquent/bad debt. When accounts are submitted to Cornerstone Credit Service an additional 35% of balance will also be added.**

# Days over due	Action
60	Statement
90	Collection warning or Cornerstone Credit Service

If an account is referred to small claims court and a judgment is rendered in the Favor of Advanced Hand & Orthopedics, in addition to your overdue balance, you will also be responsible for the payment of all court costs and attorneys fees associated with obtaining such a judgment.

ALL PATIENTS INCLUDING PATIENTS ON WORKERS COMPENSATION

** An appointment must be canceled before 24 hours prior to your scheduled visit. **A no-show charge of 1/2 hour office visit will be added to the account for all missed/non canceled appointments**. You will need to pay the no show charge at the time of your next visit or prior to rescheduling appointments. **Insurance companies do not cover no show charges--You will be ultimately responsible for these charges, not your insurance company.**

**If you misrepresent your insurance coverage collection process will begin immediately.

If you have any questions in regard to your account at any time, please feel free to contact our office.

I have read the above information and understand the financial policies presented above.

_____ _____

Guarantor/Spouse/Guardian Signature Date

My Insurance deductible has been met for the current calendar year, Yes___No___