Hand & Arm Therapy of Central Oregon

PATIENT INFORMATION FORM

Today's Date:_____

Name: _____ **Date of Birth**: _____

Address: _____**City:** _____ **State**:_____ **Zip**:_____

Primary contact number: _____ **Secondary contact number:** _____

Email: _____ **Reminder preference:** ____Phone ___Email

Sex: M / F **Height:** _____ **Weight:** _____ **Social Security #:** _____

Have you had any falls in the last 12 months? NO / YES **If yes, how many?** _____ **If yes, did an injury occur?** _____

Date of Surgery (if applicable):_____ **Date of Injury:**_____ **Cause**:_____

Referral Source: _____ **Primary Care Physician/Clinic:** _____

Estimated number of previous therapy visits used so far this year: Occupational:_____ **Physical:**_____ **Speech:**_____

Emergency Contact Name: _____ **Relationship:** _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Current Medications and Dosages:_____

_____

_____

Responsible Party Name (if minor): _____ **Relationship:** _____

Date of Birth: _____ **Address:** _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

ACCIDENT INFORMATION ***(Complete boxed section ONLY if motor vehicle accident or Workers Compensation on-the-job injury*****)**

Date of Accident: _____ **Type:** ☐WORK ☐AUTO ☐OTHER: _____

Insurance Company: _____ **Claim #:** _____

Adjuster Name: _____ **Phone #:** _____

Fax #:_____ **Employer Name** (if worker's comp): _____

I certify that the above information is true and correct to the best of my knowledge. I will notify Hand & Arm Therapy of Central Oregon of any changes made in my status in regards to the above information. I authorize release of medical information to my insurance company, physician and attorney, if applicable. As the parent/legal guardian, I authorize Hand & Arm Therapy of Central Oregon to treat my minor child.

PATIENT SIGNATURE (or Responsible Party): _____ **DATE:** _____

HAND & ARM THERAPY OF CENTRAL OREGON
Policy Disclosure Statement

NOTICE OF PRIVACY PRACTICES (HIPAA) – Effective 9/23/2013

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, it may be in the form of written or electronic records or spoken words, and it may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to maintain the privacy of your health information and to give you notice. Please review our **"NOTICE OF PRIVACY PRACTICES"** carefully for the full disclosure about your health information, your rights and our obligations regarding the use and disclosure of that information.

FINANCIAL POLICY

We are committed to providing you with the best possible medical and patient support care. If you have medical insurance, we will try to help you receive your maximum allowable benefits. As a courtesy, we will check your benefits, but it is ultimately your responsibility to know your insurance benefits and policies. **Please note that co-pays generally go towards therapy expenses while splinting is billed separately and not included with the therapy co-pay.** Please read *Hand & Arm Therapy of Central Oregon's* **"FINANCIAL POLICY"** carefully to more fully understand how your medical treatment claims will be managed.

ATTENDANCE POLICY

We understand that sometimes events occur beyond our control and for the most part missed appointments happen by accident. If you need to cancel or reschedule an appointment please call ahead. **We require at least 24 hours advance notice**: This allows us the opportunity to offer another patient your appointment time. We reserve the right to charge for missed appointments. There is a **$25 fee** for the second missed appointment (late cancel / no show). Also, care may be discontinued if you miss (late cancel / no show) three or more appointments. If circumstances exist that make it difficult for you to keep your scheduled appointments please discuss this with your therapist and we will do our best to accommodate your needs.

By signing this form, I certify that I have reviewed and agreed to the "NOTICE OF PRIVACY PRACTICES" policy, the "FINANCIAL POLICY", and the "ATTENDANCE POLICY" of *Hand & Arm Therapy of Central Oregon.*

_____ _____

PATIENT SIGNATURE (or Responsible Party) **DATE**

I am requesting a copy of:
"NOTICE OF PRIVACY PRACTICES"_____ and/or the
"FINANCIAL POLICY"_____ .

HATCO Initials:_____ Date:_____