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

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:_____

Medicare Therapy Limitations Notice

All therapy services provided on or after July 1, 2003 are now processed under new requirements issued by the Centers for Medicare and Medicaid Services (CMS). The Balanced Budget Act passed by Congress in 1997and enacted as the 1999 Balance Budget Refinement Act puts a $1960.00 cap, per beneficiary, per year for outpatient therapy for 2016.

The wording of this outpatient therapy cap combines physical and speech therapy together in one $1960.00 cap. Occupational therapy has a separate $1960.00 yearly maximum.

The therapy cap begins January 1, 2016 and outpatient physical (plus speech therapy) and occupational therapy will have a limit of $1960.00 per beneficiary between January 1, 2016 and December 31, 2016.

If you, a Medicare beneficiary, need additional treatment, you must do one of the following TWO options:

1. If you would like to continue treatment with your present therapist, you must sign a form indicating that you may be billed for the services provided over the cap. Medicare may cover additional visits over the therapy cap. Medicare will be looking for medical necessity even then, Medicare may pay and then ask for a refund at which point you will be billed for services provided.

   *Please note: Many secondary insurances will not pay on a claim that Medicare will not accept. As a result, your secondary insurance will not cover therapy visits over $1960.00 cap allowed by Medicare. You will need to personally contact your secondary insurance to see how they are going to handle the cap to therapy services.

2. You may choose to terminate therapy. Discuss this with your therapist first. We are trying to provide the services you need.

The best direction to effect change in this recent Medicare budget is to contact your state senators and representatives. Constituent complaints to Congress will cause change more quickly that health providers lobbying for an end to these caps.

By signing, I acknowledge that I understand the Medicare's therapy limitations and my options once I meet that $1960.00 yearly cap.

Patient Signature Date

Medicare Additional Screening Requirements:

Patient Name:_____ Today's Date:_____

Abuse Screening

Instructions: Please check one box for each question.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? ☐ **Yes** ☐ **No**

2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with? ☐ **Yes** ☐ **No**

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened? ☐ **Yes** ☐ **No**

4. Has anyone tried to force you to sign papers or to use your money against your will? ☐ **Yes** ☐ **No**

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? ☐ **Yes** ☐ **No**

****Front Office Score: _____**

Depression Screening

Instructions: Choose the best answer for have you have felt over the past week:

1. Are you basically satisfied with your life? Yes **No**

2. Have you dropped many of your activities and interests? **Yes** No

3. Do you feel that your life is empty? ☐ **Yes** ☐ No

4. Do you often get bored? ☐ **Yes** ☐ No

5. Are you in good spirits most of the time? ☐ Yes ☐ **No**

6. Are you afraid that something bad is going to happen to you**?** ☐ **Yes** ☐ No

7. Do you feel happy most of the time? ☐ Yes ☐ **No**

8. Do you often feel helpless? ☐ **Yes** ☐ No

9. Do you prefer to stay at home, rather than going out and doing new things? ☐ **Yes** ☐ No

10. Do you feel you have more problems with memory than most? ☐ **Yes** ☐ No

11. Do you think it is wonderful to be alive now? ☐ Yes ☐ **No**

12. Do you feel pretty worthless the way you are now? ☐ **Yes** ☐ No

13. Do you feel full of energy? ☐ Yes ☐ **No**

14. Do you feel that your situation is hopeless? ☐ **Yes** ☐ No

15. Do you think that most people are better off than you are? ☐ **Yes** ☐ No

****Front Office Score: _____**

Morse Fall Risk Assessment Tool

Patient Name:_____ Date: _____

Circle the response that best describes your current condition for each question.	**Office Use:**
1. History: Have you fallen in the last 12 months?	
a. YES	25
b. NO	0
2. Secondary Diagnosis: Do you have a secondary diagnosis in addition to the diagnosis you are here for? (i.e. High blood pressure, diabetes)	
a. YES	15
b. NO	0
3. Ambulatory Aides: Choose one of the following that best describes how you move around:	
a. I walk without a walking aid (even if assisted by a nurse), am on bed rest, or use a wheel chair.	0
b. I use crutches, a cane, or a walker	15
c. I clutch onto furniture for support when moving around.	30
4. Intravenous Therapy: Do you have an intravenous (IV) apparatus or a heparin lock inserted?	
a. YES	20
b. NO	0
5. Gait: Choose one of the following that best describes how you walk:	
a. Normal-I walk with my head erect, arms swinging freely at my side, and striding without hesitation OR I am on bed rest or immobile.	0
b. Weak- I walk stooped but am able to lift my head while walking without losing balance. My steps are short and I may shuffle.	10
c. Impaired- I walk with my head down and watch the ground. My balance is poor, so I grasp onto furniture, a support person, or a walking aid for support and cannot walk without this assistance.	20
6. Mental Status: Select one of the following:	
a. I am well oriented to my own physical abilities.	0
b. Sometimes I forget my physical limitations.	15

Scoring: ☐ **0: No Risk** ☐ **1-25:Low Risk** ☐ **25-45:Moderate Risk** ☐ **>45:High Risk**

****Front Office Score: _____**

If you've had 2 or more falls in the last year OR 1 fall with injury, please complete the backside of this page (Falls Efficacy Scale).

Falls Efficacy Scale:

Patient Name_____ Date: _____

****Only complete this side if 2 falls in the last year or 1 fall with injury in the last year****

Instructions: Circle the number that best represents your current confidence level for each activity.

Take a bath or shower

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Reach into cabinets or closets

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Walk around the house

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Prepare meals not requiring carrying heavy or hot objects

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of bed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Answer the door or telephone

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Get in and out of a chair

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting dressed and undressed

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Personal grooming (i.e. washing your face)

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

Getting on and off of the toilet

1:Very Confident 2 3 4 5 6 7 8 9 10:Not At All Confident

****Front Office Score: _____**

Hand & Arm Therapy of Central Oregon

Medication Summary

Patient Name:_____ **Date:**_____

Medication	Dosage & Frequency	Route Taken (ie: Orally / Injection)