PATIENT DEMOGRAPHIC

Name: _____ Date of Birth: _____

Social Security Number: _____ Gender: □ Male □ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____
Cell Phone: _____
Work Phone: _____

In the event Nevada Hand Therapy needs to contact you or leave a message with detailed information, which phone number do you prefer? Please circle one.

Name of Spouse/Emergency Contact: _____ Phone Number: _____

Are there any people that we may release personal information to? (including appointment dates and times, medical information, etc.) Please list them: _____

Referring Physician: _____

Name of Insurance Company _____ Phone Number _____

ID#, Claim# or SS# _____ Group # _____

Is this a worker's compensation claim (work-related injury)? □ Yes □ No

Employer: _____ **Phone Number**: _____

WORK INFORMATION

Are you currently employed? □ Yes □ No

Work status: □ Full-duty □ Light-Duty □ Off-duty □ Restrictions

What is your job title? _____ What are your job duties/responsibilities? _____

Patient/Guardian Signature: _____ **Date**: _____

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Have you had Occupational Therapy this calendar year? □ Yes □ No

If YES, how many visits?_____Where? _____

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

Cardiac Heart Failure	Cancer	Stroke
Pacemaker	High Blood Pressure	Head Injury
Cardiovascular Disease	Diabetes	Neck or Back pain
Irregular Heart rate	Arthritis	Pregnancy

Other (please list): _____

Please check if you are a □ non-smoker □ smoker If yes, how many per day? _____

Do you drink? Yes___ No___If yes, how much and how often (drinks per day, drinks per week)? _____

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

Please indicate any allergies you may have. □ Steroid □ Adhesives □ Beeswax □ Latex

□ Other allergies, please specify: _____

Are you taking any medications? Please list: _____

_____

Have you had any of the following tests performed for your current injury or problem?

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

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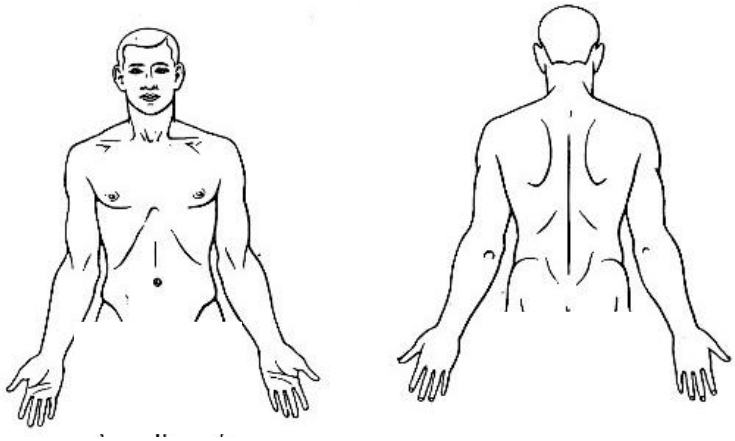
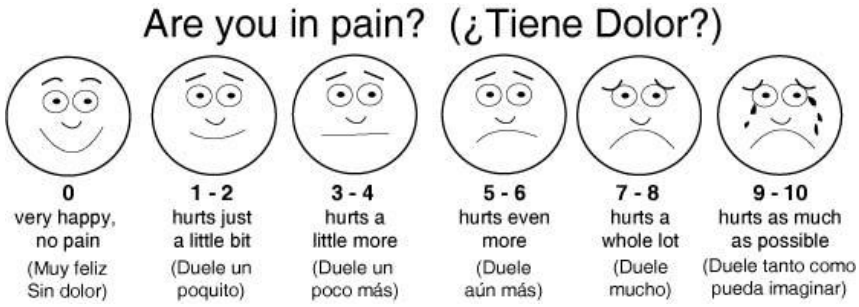
SYMPTOMS

Please use this diagram to circle any problem areas. Use "O" to indicate areas of pain and use "X" to indicate areas of numbness or tingling:



PAIN

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



TELL US ABOUT YOUR CURRENT CONDITION…

Date of injury: _____ Date of surgery (if applicable): _____

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

_____

Have you ever had these symptoms before? When? _____

Any previous treatment for this problem? _____

Have you tried any braces and/or splints? _____

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

_____

What are your goals in coming to therapy? _____

Is there anything we need to know that is not covered in this form? If yes, please explain below.

_____

Understanding of Nevada Hand Therapy Policies

I authorize treatment of the person named and agree to pay all fees and charges for such treatment. I authorize the release of my medical or other information necessary to process my claims. I authorize payment of medical benefits directly to Nevada Hand Therapy, LLC, for services described. Charges shown by statements are agreed to be true and reasonable unless protested in writing within 30 days of the billing date.

Center for Medicare Services (CMS): Medicare Limits on Therapy Services

For calendar year 2017, the CMS (Center for Medicare & Medicaid Services) policy for outpatient occupational therapy cap is $**1960**. This financial cap is separate from physical therapy and speech-language therapy. If occupational therapy services exceed this $**1960**. cap and exceptions beyond this financial limit, the remaining balance will be the patient's responsibility. Medicare does allow certain diagnoses to go beyond the standard cap. For more information about this, please contact our front desk. For more information on Medicare Part B outpatient therapy caps and the exceptions process, visit http://www.cms.gov/.

Notice of Privacy Practices Patient Receipt

Your signature below acknowledges that you have received a copy of Nevada Hand Therapy's Notice of Privacy Practices. The Notice of Privacy Practices provides you with information about how Nevada Hand Therapy may use or disclose your protected health information. We encourage you to read it in its entirety.

_____ _____

Patient Signature **Date**

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24-Hour Cancellation Policy

At Nevada Hand Therapy, we strive to maintain appointment schedule time, reduce unnecessary wait times, and allow patients to be seen quickly after a physician refers them to us. One of the factors which strongly influences our ability to do this is the failure of patients to show for scheduled appointments without adequate cancellation notice. We require **24-hour notice** of cancellation so that we may give your appointment time to another patient who may need it. If you know that you cannot make your scheduled appointment, please call us to let us know. We understand that occasionally there may be unavoidable circumstances that cause you to miss your appointment. These will be evaluated on a case by case basis.

We reserve the right to bill you **$50.00** for any missed appointment if we are not given **24 hours' notice**. Again, we realize that there are emergencies and unavoidable circumstances that may cause you to miss your appointment without being able to give us **24 hours' notice**. We will evaluate these situations on a case by case basis and will consider waiving the cancellation fee if certain criteria are met.

WORKER'S COMPENSATION PATIENTS:

We reserve the right to notify your claims adjuster, case manager, and/or physician after **THREE MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE**. We may also cancel all future appointments until you have returned to your physician for a new prescription.

Your signature below indicates that you have read a copy of our 24-hour cancellation policy.

_____ _____

Patient Signature **Date**