



Hand Therapy Partners

Custom Splinting · Shoulder to Fingers · Same Day Visits · Pediatric Hand Therapy

Today's Date _____

Patient First Name _____ MI _____ Last Name _____
Date of Birth _____ Sex: Male Female
Address _____
City _____ State _____ Zip _____
Email Address _____
Home Phone _____ Cell Phone _____
Social Security # (If Needed for Insurance) _____

Responsible Party:

Name: _____ Relationship to Patient _____
Address (if different from above) _____
City _____ State _____ Zip _____
Primary Contact Phone Number _____

Primary Insurance _____
Member ID # _____ Group # _____
Insured Name _____ Insured Date of Birth _____
Insured Relationship to Patient _____

Secondary Insurance _____
Member ID # _____ Group # _____
Insured Name _____ Insured Date of Birth _____
Insured Relationship to Patient _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Are you receiving, or have you recently received home health services?

Yes No

Are you receiving, or have you received other therapy services this calendar/plan year?

Yes No



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Medical History

Today's Date _____

Patient's Name _____

Date of Birth _____

Date of Injury _____

Date of Surgery _____

Is this related to an accident? Yes No

If accident: Work Auto Other: _____

Injured area: _____ Left Right

How did injury occur?

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Therapy/Splint goals _____

Allergies _____

Current Medical Conditions : Hepatitis/HIV Diabetes Cardiac Problems Cancer

Other: _____

Current Medications _____



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The Disabilities of the Arm, Shoulder and Hand Score(QuickDash)

Clinician's name (or ref)

Patient's name (or ref)

INSTRUCTIONS: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer *every question*, based on your condition in the **last week**. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on you ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week.

1. Open a tight or new jar	<input type="radio"/> No difficulty	<input type="radio"/> Mild difficulty	<input type="radio"/> Moderate difficulty	<input type="radio"/> Severe difficulty	<input type="radio"/> Unable
2. Do heavy household chores (eg wash walls, wash floors)	<input type="radio"/> No difficulty	<input type="radio"/> Mild difficulty	<input type="radio"/> Moderate difficulty	<input type="radio"/> Severe difficulty	<input type="radio"/> Unable
3. Carry a shopping bag or briefcase	<input type="radio"/> No difficulty	<input type="radio"/> Mild difficulty	<input type="radio"/> Moderate difficulty	<input type="radio"/> Severe difficulty	<input type="radio"/> Unable
4. Wash your back	<input type="radio"/> No difficulty	<input type="radio"/> Mild difficulty	<input type="radio"/> Moderate difficulty	<input type="radio"/> Severe difficulty	<input type="radio"/> Unable
5. Use a knife to cut food	<input type="radio"/> No difficulty	<input type="radio"/> Mild difficulty	<input type="radio"/> Moderate difficulty	<input type="radio"/> Severe difficulty	<input type="radio"/> Unable
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg golf, hammering, tennis, etc)	<input type="radio"/> No difficulty	<input type="radio"/> Mild difficulty	<input type="radio"/> Moderate difficulty	<input type="radio"/> Severe difficulty	<input type="radio"/> Unable

7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?

Not at all Slightly Moderately Quite a bit Extremely

8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?

Not limited at all Slightly limited Moderately limited Very limited Unable

Please rate the severity of the following symptoms in the last week

9. Arm, shoulder or hand pain	<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Extreme
10. Tingling (pins and needles) in your arm, shoulder or hand	<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Extreme

11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?

No difficulty Mild difficulty Moderate difficulty Severe difficulty So much difficulty I can't sleep

11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
0	2	5	7	9	11	14	16	18	20	23	25	27	30	32	34	36
28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44
39	41	43	45	48	50	52	55	57	59	61	64	66	68	70	73	75
45	46	47	48	49	50	51	52	53	54	55						
77	80	82	84	86	89	91	93	95	98	100						



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Patient Insurance and Financial Responsibilities

I understand that I am expected to pay for services at the time of service. Depending on my insurance plan, this may be payment in full, a co-payment, a deductible amount and/or co-insurance.

If I am a member of an insurance plan that Hand Therapy Partners (HTP) is not contracted with, I will be required to pay for services in full at the time of service. I can then submit my own claim for reimbursement.

If my insurance company is a managed care plan, it is my responsibility to be sure that necessary referrals and/or authorizations are obtained prior to treatment. If the appropriate referrals and/or authorizations are not obtained, my appointment will be canceled or delayed until this information is obtained. I understand that even though services may be pre-authorized, not all services may be covered or paid for by my insurance plan.

I authorize release of any medical information and/or records necessary to process insurance claims. I authorize HTP to apply for benefits on my behalf for covered services. I also assign all benefits directly to HTP. I certify that the information that I have reported is correct and true. I permit a copy of this authorization to be used in place of the original. My signature below also provides my consent to treat my minor child.

If I am a Medicare beneficiary, I request payment of authorized Medicare benefits on my behalf for any services furnished to me by HTP and authorize HTP to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

I understand I am financially responsible for any charges incurred by me and/or my dependents. I understand that in the event that my account is assigned to a collection agency, I agree to pay an additional collection fee of 10% of the outstanding balance assigned. I also agree to pay any interest on the principal balance, court costs and attorneys' fees associated with the collection of my account.

Patient or Guardian Signature

Patient Date of Birth

Printed Name of Patient

Date



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Acknowledgment of HIPAA Privacy Policies

I understand that as part of my healthcare, Hand Therapy Partners (HTP) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which an insurance carrier can verify that services billed were actually provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of healthcare professionals

I understand, and have been provided with a Notice of Privacy Practices, which provides a complete description of these uses and disclosures. I have reviewed the Notice of Privacy Practices before signing below. I understand that the terms of the Notice of Privacy Practices may change and then I may request a copy of these changes in writing to the HTP Privacy Officer.

I understand that I have the right to request restrictions as to how my health information is released for the purposes of treatment, payment and health care operations. I understand that I have the right to revoke this consent, in writing, at any time by providing written notification to HTP.

I hereby give consent to HTP to use and/or disclose my protected health information for the purposes of treatment, payment and health care operations. I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to HTP.

Signature of Patient or Personal Representatives

Patient Date of Birth

Printed Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority



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Authorizations to Use/Disclose Protected Health Information

Glendale Clinic	9980 N Glendale Ave #110, Glendale, AZ 85307	P: 623-226-8804	F: 602-532-7839
Mesa Clinic	430 N Dobson Rd #103, Mesa, AZ 85201	P: 480-565-2276	F: 480-383-6789

I hereby authorize the use and/or disclosure of all of my personal health information by Hand Therapy Partners as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan or healthcare provider, the release information may be re-disclosed and may no longer be protected by the federal privacy regulations.

1. Person or organization authorized to receive the health information:

2. Description of each purpose for which the health information will be used/disclosed (Note: Not required if disclosure is requested by the individual):

3. I understand that the person or organization that I am authorizing to use/discard the information may receive compensation in exchange for the health information described above.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits.* (Note: Not required if disclosure is requested by the individual).

5. I understand that I may revoke this authorization at any time by providing written notice to: Cary B. Edgar, Hand Therapy Partners LLC, 3241 E. Camelback Road, Phoenix, AZ 85018. I understand that my revocation will not affect any action already taken in reliance on this authorization.

6. I understand I may inspect or copy any information to be used or disclosed under this authorization.

7. Unless otherwise revoked in writing, this authorization will automatically expire one year from the date I sign below.

Signature of Individual (or Legal Representative)

Date

Individual's Name (Print)

Name of Legal Representative, if applicable (Print)

Relationship

*A health plan may condition enrollment or eligibility for benefits on an individual providing an authorization prior to enrollment if the authorization sought is for the plan's eligibility or enrollment determinations relating to the individual or for its underwriting risk or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(4)(ii)(A&B)).



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You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit [cms.gov/nosurprises](https://www.cms.gov/nosurprises) or 1-800-985-3059.