WELCOME TO HAND THERAPY SERVICES

Patient Name: ______________________________ A.K.A________ Today's Date: ______

Address: ____________________________ City/State/Zip: ______________________

Home Phone: (____) __________________ Cell Phone: (____) ____________________

E-Mail Address: ____

Social Security Number: _____________________ Date of Birth: _______ Age_______

Male / Female   Married / Single / Widowed   Which hand is your dominant hand? Right / Left

Employer: _________________________________ Work Phone: (____) _____________

Job Title: ____

Address: ____________________________ City/State/Zip: ______________________

Race: ___American Indian/Alaska Native ___Asian ___Black/African American ___White
___More than one race ___Native Hawaiian ___Pacific Islander ___Unreported/Refused to report
Ethnicity: ___Hispanic/Latino ___Non-Hispanic/Latino ___Unreported/Refused to report

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PRIMARY Insurance Name: ____

Date of Accident: ___________________________ Date of Surgery: _______________

Guarantor's Name: __________________________ Relationship____________________

Social Security Number: ____________________________ Date of Birth: ___________

Guarantor's Address: ______________________________ City/State/Zip___________

SECONDARY Insurance Name: ____

Guarantor's Name: __________________________ Relationship____________________

Social Security Number: ____________________________ Date of Birth: ___________

Guarantor's Address: ______________________________ City/State/Zip___________

Referring Doctor's Name: ____

IN CASE OF EMERGENCY CONTACT: ____

Address: ____________________________ City/State/Zip: ______________________

Phone Number: (____) ________________ Relationship: ________________________

PLEASE ANSWER ALL OF THE FOLLOWING:

Briefly describe your injury: ____

Have you had surgery? _____Yes _____No If yes, when?____________________

Are you taking medication for:

___Pain ___Diabetes ___Blood Pressure ___Cholesterol

___Heart ___Thyroid ___Vertigo ___Blood Thinner

___Rheumatoid Arthritis Other:____

In general, you would rate your overall health as: __Excellent __Good __Fair __Poor

Have you ever experienced heart problems, including heart surgery?

_____Yes _____No

Do you have a pacemaker? _____Yes _____No

Have you ever tested positive for tuberculosis? _____Yes _____No

Do you have diabetes? _____Yes _____No

Do you have a history of seizures? _____Yes _____No

Do you have a history of dizziness? _____Yes _____No

Do you have a history of hypertension? _____Yes _____No

Do you have any joint problems, muscle problems or injuries? _____Yes _____No

If yes, please explain:____

Are you allergic to Latex? ____

Do you have neck problems including neck surgery? _____Yes _____No

If yes, please explain:____

____

What are your hobbies/sports?______________________________________

Are you able to perform them at this point? _____Yes _____No

If employed, are you working at this time? _____Yes _____No

If yes: _____Light Duty _____Modified Duty _____Regular Duty _____Not employed

Were you seen by a therapist or a chiropractor regarding this injury before your doctor referred you to us? _____Yes _____No

If yes, how many weeks were you treated?______________________________

______________________________ ______________________________

Signature Date

Hand Profile

RATE YOUR PAIN

Rate the average amount of pain in your wrist/hand over the past week by circling the number that best describes your pain on a scale from 0-10. A zero (0) means that you did not have any pain and a ten (10) means that the pain is the worst possible (i.e worst you have ever experienced or that you could not do the activity because of pain)

At Rest

None — Worst

0 1 2 3 4 5 6 7 8 9 10

When doing a task with a repeated wrist/hand movement

None — Worst

0 1 2 3 4 5 6 7 8 9 10

When lifting a heavy object

None — Worst

0 1 2 3 4 5 6 7 8 9 10

When it is at its worst

None — Worst

0 1 2 3 4 5 6 7 8 9 10

How often do you have pain

Never — Always

0 1 2 3 4 5 6 7 8 9 10

SPECIFIC ACTIVITIES

Rate the amount of difficulty you experienced performing each of the items listed below - over the past week, by circling the number that describes your difficulty on a scale of 0-10. A zero (0) means you did not experience any difficulty and a ten (10) means it was so difficult you were unable to do it at all

Turn a door knob using my affected hand

No Difficulty — Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Cut meat using a knife in my affected hand

No Difficulty — Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Fasten buttons on my shirt

No Difficulty — Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Use my affected hand to push up from a chair

No Difficulty — Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Carry a 10lb object in my affected hand

No Difficulty — Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Use bathroom tissue with my affected hand

No Difficulty Unable To Do

0 1 2 3 4 5 6 7 8 9 10

USUAL ACTIVITIES

Rate the amount of difficulty you experienced performing your usual activities in each of the areas listed below, over the past week, by circling the number that best describes your difficulty on a scale of 0-10. By ?usual activities?, we mean the activities you performed before you started having a problem with your wrist/hand. A zero (0) means that you did not experience any difficulty and a ten (10) means it was so difficult you were unable to do any of your usual activities

Personal care activities (dressing, washing)

No Difficulty Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Household work (cleaning, maintenance)

No Difficulty Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Work (your job or usual everyday work)

No Difficulty Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Recreational activities

No Difficulty Unable To Do

0 1 2 3 4 5 6 7 8 9 10

Appearance - Optional

How important is the appearance of your hand

Very Much Somewhat Not at all

Rate how dissatisfied you were with the appearance of your wrist/hand during the past week.

No Dissatisfaction Complete Dissatisfaction

0 1 2 3 4 5 6 7 8 9 10

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SHEA PHYSICAL THERAPY/HAND THERAPY SERVICES

Policy for Cancellations and No Shows

These policies have been developed to assist our therapist in scheduling their patients efficiently so that each of you will be given the appropriate time when you arrive for your treatment session. We appreciate you assisting us in the matter of **cancellations** and **no shows** for our operation.

1. We will request a 24 hour notice in the event of a cancellation. It is the patient's responsibility, when you call in, to have an alternative time in mind that will ensure that you get in the full prescribed number of treatments that week whenever possible.

2. Please understand that when you do not show, three people are affected:

   a) First the patient because you do not get the treatment you need as prescribed by the doctor.

   b) Second, the therapist who now has a space in their schedule since the time was reserved for you personally.

   c) Third, another patient could have been scheduled for treatment if there had been proper notice.

   Should you have to reschedule, please understand that you may need to see a clinician other than the one who normally treats you as a result of rearranging the appointment period. All of our clinicians are experienced professionals, and they will study your chart, so you will be in good hands. You will return to the original clinician in the next regularly scheduled visit.

Should you need to cancel or change an appointment, please contact our office directly; for Shea Physical Therapy (361) 994-5224 and for Hand Therapy Services (361) 992-1435. Again this policy is to assist our facility to offer you the patient a much more efficient operation. We strive to minimize the amount of wait time that you may have in our lobby by keeping our therapists on a regular schedule.

We look forward to having the opportunity to work with you and to assist you in your current therapy need.

Sincerely,

Daniel R. Shea, P.T
Shea Physical Therapy

Sheila Heflin, OTR, CHT
Hand Therapy Services

Patient Signature________________________________ Date_________________

Consent for Treatment / Privacy Policy / Assignment of Benefits

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills are handled.

EXPLAINATION OF INSURANCE COVERAGE

Most insurance policies cover occupational therapy, but this office does not ensure that yours does. Insurance policies can differ greatly in terms of coverage for occupational therapy. Because of the variance of one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and we will bill your insurance company (ies) in a timely manner.

I. ASSIGNMENT OF BENEFITS

Authorization of payment: I hereby assign all benefits directly to Hand Therapy Services. If my insurance carrier sends me payment for services incurred in this office, I shall send or bring the full payment to your office immediately upon receipt. I understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment in full.

______________________________ Signature

________________ Date

II. SUMMARY OF BENEFITS:

Deductible: $_______-has been met\not met $_______coverage % _____Co-pay$____

- Your insurance carrier(s) covers the following:
  _____ visit(s)/dollar(s) per calendar year. _____ Procedure(s) per visit.
- The following services are not covered by your insurance carrier:
  ____
- _____ Your insurance will not cover these services and you will be responsible for payment of the services you receive.

Terms of Benefits

This is a description of benefits, only as given by your insurance company. This information is provided to you as a courtesy only. It is the paitents responsibility to check with your insurance to verify benefits / coverage. Summary of benefits is not a guarantee of payment and is subject to change. I fully understand that any unpaid portion ofservices rendered is my responsibility. Quotes are an estimated calculation, according to the description of benefits given by my insurance company. I agree to the terms and conditions presented to me by Hand Therapy Services.

I acknowledge and accept the terms and conditions set forth in Sections I and II of this statement:

______________________________ Signature

________________ Date

III. CONSENT FOR RELEASE OF INFORMATION

The undersigned authorizes the release of any personal health information required for treatment, payment or health care operations. This may include physicians, case managers and insurance carriers or third party payers. Further, the undersigned releases Hand Therapy Services to provide outside healthcare providers/services such information as is necessary to facilitate proper healthcare. In addition, the patient consents to the release of prior medical records from referring physicians, hospitals, case managers, or other entities, which have records necessary for proper evaluation and treatment of the patient. All other uses and disclosures will be made only with your written authorization. You have the right to revoke authorization for further uses and disclosures at any time.

IV. CONSENT FOR TREATMENT

I consent to rehabilitation and incidental medical services at Hand Therapy Services. I understand the expected benefits, possible risks, side effects, complications and discomforts of my rehabilitation. I know and agree that Hand Therapy Services is not responsible for loss or damage to personal valuables.

V. PRIVACY POLICY

Hand Therapy Services will administer your records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. I have received a copy of the notice of privacy Practices.

I acknowledge and accept the terms and conditions set forth in Sections III, IV and V of this statement.

____________________________ __________________
Patients' Signature Date

____________________________ __________________
Witness' Signature (staff) Date

We hope this answers any questions you might have concerning the financial policies of this office. Once again we welcome you to our office and will be glad to answer any further questions you might have.

If the patient is a minor, or legally incapacitated, please obtain the signature of a parent or a guardian.

HAND THERAPY SERVICES

SUPPLIES/HOME EQUIPMENT

Your insurance company may or may not cover certain supplies or home equipment issued to you by our facility. **Supplies** are those items required to carry out a specific treatment order (i.e. electrodes, lumbosacral rolls, instruction booklets, etc.). **Home Exercise Equipment** are those items which may be used to enhance your rehabilitation at home (i.e. theratubing, hand putty, weights, pulleys, etc.).

We try to purchase these items in bulk thus reducing the cost of these items. This savings is then passed on to the patients/insurance companies. We try to keep the pricing of these items extremely fair as we realize the purchase of these items may become the patient's responsibility.

You always have the right to choose whether or not you would like to personally purchase the equipment should your insurance company not cover those items. The supplies, however, are required for your treatment and will be your responsibility should your insurance not cover those items.

Please check with the front desk concerning your insurance coverage. An itemized list of equipment and prices will be shown to you so that you may decide if you would like to purchase the item.

If you have any questions, please do not hesitate to discuss with our office.

Thank you.

I have read and understand the above policy: ______________________________
Signature

____
Date

SHEA PHYSICAL THERAPY
HAND THERAPY SERVICES

January 1, 2022

To our Medicare patients:

MEDICARE BENEFICIARIES:

Effective January 1, 2022, Congress has permanently extended the current exceptions process for physical and occupational therapy. For the calendar year 2022 this amount is $2,150.00 for physical and speech therapy services combined and $2,150.00 for occupational therapy. Therapy claims for outpatient Medicare Part B services that go above $2,150.00 will require the use of a modifier for attestation that claims are medically necessary which may provide a higher threshold to $3,000.00, at which a targeted medical review process kicks in.

We will work with you individually to assist in determining your benefits. We will be requesting you to sign this notice (a requirement of Medicare), to acknowledge that we have educated you regarding this benefit. This threshold is for outpatient services only. If it is determined that therapy is "not reasonable and necessary", you may be requested to pay out of pocket.

POSSIBLE REQUIRED DEDUCTIBLE:

Also, ***Medicare typically has an annual deductible of $233.00 before your benefits begin for the rest of the year.*** Some secondary insurances may cover this deductible, others will not. Therefore, we will assist you in identifying your financial responsibility and will need to collect this amount if required.

We will be closely monitoring our service so we can provide you with the highest quality care available.

Should you have any questions regarding any of this information, please do not hesitate to ask.

Thank you,

Shea Physical Therapy
Hand Therapy Services

Patient Signature ______________________ Date ____________

SHEA PHYSICAL THERAPY
HAND THERAPY SERVICES
Medicare Patients

1. In the 2022 calendar year, have you received any of the following:

	Circle one	if yes, where?
physical therapy?	yes/no	
occupational therapy?	yes/no	
speech therapy?	yes/no	
home health services?	yes/no	
treatment at an outpatient facility?	yes/no	
seen at a doctor's office?	yes/no	

2. Have you had home assistance for:

	Circle one	if yes, by whom?
bathing?	yes/no	
household chores?	yes/no	
monitoring blood pressure?	yes/no	
administering injections?	yes/no	

3. Have you been hospitalized within the last 30 days? yes/no

   If yes, where?______________________________

   If yes, for what?______________________________

4. When did you receive any of these previous treatments or assistance?

   Start date________________ Last date treated ________________

5. Are you currently receiving home health? yes/no

6. Is a nurse scheduled to see you? yes/no If yes, when?________________

Patient Signature______________________________ Date________________

Witness______________________________ Date________________

Medicare Secondary Payer (MSP) Form

Patient name: ______________________________ Acct#: ______________

Medicare requires us to identify if Medicare is the primary or secondary payer, please answer all the required questions below.

Part I - INFORMATION ABOUT BLACK LUNG, WORKERS' COMPENSATION (WC), NO-FAULT AND LIABILITY

1. Are you receiving benefits under the Black Lung Program? ☐ Yes ☐ No
   If yes, date benefits began ______________
   Black lung is primary payer only for claims related to black lung.
2. Was this injury/illness due to a work-related accident/condition? ☐ Yes ☐ No
   If yes, date of injury/illness ______________; *Please provide the WC information.*
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?
   ☐ Yes ☐ No
   If yes, date of accident ______________
   Is no-fault insurance available? ☐ Yes ☐ No
   If yes, please provide no-fault insurance information.
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? ☐ Yes ☐ No *If yes, please provide the Attorney's information.*

(If answered YES to any of the questions above, Medicare is the secondary payer and you do not need to fill out Part II or III)

Part II - INFORMATION ABOUT MEDICARE ENTITLEMENT AND GROUP HEALTH PLANS

1. Are you entitled to Medicare based on:
   ☐ Age (65 & older) – go to question #2
   ☐ Disability – go to question #2
   ☐ End Stage Renal Disease— Go to Part III
2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? ☐ Yes ☐ No
   If yes, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:
   ☐ Aged (65 & over) - If you are aged and there are 20 or more employees, your GHP is primary.
   ☐ Disability - If you are disabled and your employer, spouse, or family member employer, has 100 or more employees, your GHP is primary.

Part III - INFORMATION ABOUT THE PATIENT IF ESRD MEDICARE ENTITLEMENT APPLIES

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.

1. Do you have group health plan coverage? ☐ Yes ☐ No
2. Are you within the 30-month coordination period? ☐ Yes ☐ No
   If yes to both questions, GHP is primary during the 30-month coordination period.

______________________________ ______________

Signature of Patient/Representative Date

Relationship to patient: ______________________________