Shea Physical Therapy | Hand Therapy Services OF CORPUS CHRISTI

PATIENT INFORMATION:

Date: _____

Patient Name: _____ A.K.A_____

Address: _____ City/State/Zip: _____

Home Phone: (____)_____ Cell Phone: (____)_____

E-Mail Address: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

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

Employer: _____ Work Phone: (____)_____

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: _____

Date of Injury: _____ Date of Surgery: _____

Guarantor's Information:

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Relationship: _____

SECONDARY Insurance: _____

Guarantor's Information:

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Relationship: _____

Referring Doctor: _____

EMERGENCY CONTACT: Name: _____

Relationship: _____ Phone Number: (___)_____

Address: _____ City/State/Zip: _____

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Please answer the following questions:

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? ____ Yes ____ No

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

In the past year, did you see a therapist or a chiropractor regarding this injury before your doctor referred you to us? ____ Yes ____ No

If yes, how many visits? _____

_____ _____
Signature **Date**

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 to call in and have an alternate day/time in mind that will ensure that you get the full prescribed number of treatments.**
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 your doctor.**
    B. **Second, the therapist. Who now has a space in their schedule since that 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 our clinicians are experienced professionals that will study your chart before your appointment. 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 *Shea Physical Therapy (361-994-5224)* or *Hand Therapy Services of Corpus Christi (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 assist you in your current therapy need.

Sincerely,
Shea Physical Therapy &
Hand Therapy Services of Corpus Christi

_____ _____

Signature **Date**

Shea Physical Therapy | Hand Therapy Services OF CORPUS CHRISTI

Consent to Treatment/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient performed by the staff at Shea Physical Therapy/Hand Therapy Services and/ or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these directly to Shea Physical Therapy/Hand Therapy Services. I authorize the filing of claims to my insurance plan and authorize Shea Physical Therapy/ Hand Therapy Services to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/ or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the notice.

Summary of Benefits

Primary Insurance Coverage:
Deductible $_____ Met / Not Met Remaining Deductible $_____ Coverage _____%
Copay $_____ Out of Pocket _____ Met / Not Met Visit Limit _____
Dollar Amount $_____ Per calendar year. _____ Procedure(s) per visit
The following services are *NOT COVERED* by your insurance carrier:
_____

Secondary Insurance Coverage:
Deductible $_____ Met / Not Met Remaining Deductible $_____ Coverage _____%
Visit Limit _____ Secondary will pick up _____

Terms of Benefits

This is an estimation of benefits given by your insurance company. This information is provided to you as a courtesy only. It is the patient's responsibility to check with their insurance company to verify benefits/coverage. Summary of benefits is not a guarantee of payment and is subject to change. I fully understand that any unpaid balances are my responsibility. I agree to the terms presented to me by Shea Physical Therapy/Hand Therapy Services of Corpus Christi.

_____ _____
Signature **Date**

_____ _____
Witness **Date**

Shea Physical Therapy | Hand Therapy Services OF CORPUS CHRISTI

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, pulley, 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. We try to keep the price 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 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 front office.

Thank you,

I have read and understand the above policy.

_____ _____

Signature **Date**