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: _________________________

Shea Physical Therapy | Hand Therapy Services OF CORPUS CHRISTI

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

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 (10) means it was so difficult you were unable to do it at all.

Turn a doorknob 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 or your wrist/hand during the past week.

No Dissatisfaction　　　　Complete Dissatisfaction

0　1　2　3　4　5　6　7　8　9　10

Shea Physical Therapy | Hand Therapy Services OF CORPUS CHRISTI

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**

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**

Shea Physical Therapy | Hand Therapy Services OF CORPUS CHRISTI

January 01, 2023

To our Medicare patients,

Medicare Beneficiaries

Effective January 01, 2023, congress has permanently extended the current exceptions process for physical and occupational therapy. For the calendar year 2023 Dollar Amount Limit is $2,230.00 for physical and speech therapy services combined and $2,230.00 for occupational therapy. Therapy claims for outpatient Medicare Part B services that go above $2,230.00 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 sigh 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 $226.00 before your benefits begin for the rest of the year.* Some secondary insurance 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 services 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,

________________________________ ________________

Signature **Date**

Shea Physical Therapy | Hand Therapy Services OF CORPUS CHRISTI

1. In the 2023 calendar year, have you received any of the following:

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 ______________________________

2. Have you had any home assistance for:

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 ____________________ End date ____________________

5. Are you currently receiving home health? Yes / No
6. Is a nurse scheduled to see you? Yes / No If yes, when? ____________________

______________________________ ____________________
Signature Date

______________________________ ____________________
Witness Date

MEDICARE SECONDARY PAYER (MSP) FORM

Name:

Part I

1. Are you receiving benefits under the Black Lung Program? If yes, date benefits began: ______________________________	☐ Yes	☐ No
2. Was this injury/illness due to a work-relatedaccident/condition? If yes, date of injury/illness: ______________________________	☐ Yes	☐ No
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: __________________________________	☐ Yes	☐ No
Is no-fault insurance available?	☐ Yes	☐ No
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: Attorney's Name: _________ Address: _________ Phone Number: _________ If you answered **NO** to all questions, go to Part II. If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.	☐ Yes	☐ No

Part II

1. Are you entitled to Medicare based on? *Check the box that applies*
   - ☐ Age (65 & older) – go to question #2
   - ☐ Disability – go to question #2
   - ☐ End Stage – 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? If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:	☐ Yes	☐ No
☐ Aged (65 & over) - If you are aged and there are 20 or more employees, your GHP is primary.	☐ Yes	☐ No
☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, your GHP is primary.	☐ Yes	☐ No

Part III

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

Please provide a copy of your group health insurance if determined to be primary.

Signature of Patient/Representative:	Date:

Relationship to Patient: