



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

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: _____

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
0 1 2 3 4 5 6 7 8 9 10 Worst

When doing a task with a repeated wrist/hand movement

NONE
0 1 2 3 4 5 6 7 8 9 10 Worst

When lifting a heavy object

NONE
0 1 2 3 4 5 6 7 8 9 10 Worst

When it is at its worst

NONE
0 1 2 3 4 5 6 7 8 9 10 Worst

How often do you have pain?

Never
0 1 2 3 4 5 6 7 8 9 10 Always

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
0 1 2 3 4 5 6 7 8 9 10 Unable To Do

Cut meat using a knife in my affected hand

No Difficulty
0 1 2 3 4 5 6 7 8 9 10 Unable To Do

Fasten buttons on my shirt

No Difficulty
0 1 2 3 4 5 6 7 8 9 10 Unable To Do

Use my affected hand to push up from a chair

No Difficulty
0 1 2 3 4 5 6 7 8 9 10 Unable To DO

Carry a 10lb object in my affected hand

No Difficulty
0 1 2 3 4 5 6 7 8 9 10 Unable To Do

Use bathroom tissue with my affected hand

No Difficulty

0 1 2 3 4 5 6 7 8 9

Unable To Do

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

0 1 2 3 4 5 6 7 8 9

Unable To Do

10

Household work (cleaning, maintenance)

No Difficulty

0 1 2 3 4 5 6 7 8 9

Unable To Do

10

Work (your job or usual everyday work)

No Difficulty

0 1 2 3 4 5 6 7 8 9

Unable To Do

10

Recreational activities

No Difficulty

0 1 2 3 4 5 6 7 8 9

Unable To Do

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

0 1 2 3 4 5 6 7 8 9 10

Complete Dissatisfaction

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 _____ %
Copoly \$ _____ 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

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