San Juan Hand Therapy Inc.

Please fill out completely and sign where indicated

Patient Information

Today's Date: _____ Date of Injury: _____ Date of Surgery: _____

Last Name_____ First Name_____ MI_____

Mailing Address_____ City _____ State _____ Zip _____

Street Address (if different than mailing) _____

Sex (Circle one) Male Female N/A Date of Birth _____/_____/_____ Age_____

(Height_____ Weight_____ Tobacco User? _____) Currently Employed? _____

Social Security #_____-_____-_____ Employer_____

Phone Numbers: (Circle preferred contact) Email: _____

Home (_____) _____ Work (_____) _____ Cell (_____) _____

Referring Physician(s) _____

Emergency Contact_____ Relationship_____ Phone_____

Responsible Party (for billing purposes)

Self? _____

Last Name_____ First Name_____

Address (if not same as above) _____

Sex: (circle one) Male Female Other Date of Birth _____/_____/_____

Relationship: (circle one) Spouse Parent Employer_____

Social Security # _____-_____-_____ Phone_____

Insurance Information

Do you have health insurance? (Circle one) Yes No

Name of Insurance Provider: Primary _____ Secondary_____

Please provide your health insurance card(s) and ID for copying

Is this visit related to a work injury? _____ if yes, name of adjuster_____

Is this visit related to an auto accident? _____

Are you currently under a Home Health Plan of Care or inpatient at a Skilled Nursing Facility? _____

Are you currently being treated by any other therapist (physical, occupational, or speech)? _____

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Are you currently experiencing pain? _____

If so, where? _____

Please rank your pain on the scale from 0-10 (0= no pain, 10= unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

_____

Please list your goals you would like to accomplish/address through hand therapy

_____
_____
_____

Signatures:

I authorize payment of medical benefits to San Juan Hand Therapy for these services and all future claims:

X_____

I authorize the release of any medical information necessary to process this claim and all future claims:

X_____

I have seen and am aware of the Privacy Policies in effect at San Juan Hand Therapy and understand that my personal information will only be shared per HIPAA requirements (located on the laminated page of your clip board)

X_____

Financial Policy:

I understand that while San Juan Hand Therapy will bill my insurance company, I am responsible for any co-payments, deductibles and non-covered supplies or treatment as well as notification of any changes to my insurance during treatment:

X_____

Cancellation Policy:

I understand that cancellations or no-shows will result in a $35 fee if we are not notified at least 24 hours in advance.

X_____

For Worker's Compensation Claims:

I understand that I must have a valid claim in effect to have services covered through Worker's Compensation:

X_____

How did you hear about us? _____