# Patient Release of Information and Assignment of Benefits

Patient Name:

_____

Emergency Contact:

_____

Name Phone Number

I agree to assign payment, be made directly to The Institute for Hand and Upper Extremity Rehabilitation, Inc., by my insurance carrier. I understand that the financial contract is between myself and the insurance company. Any payments made to me in behalf of The Institute for Hand and Upper Extremity Rehabilitation for services rendered will be turned over to The Institute for Hand and Upper Extremity Rehabilitation.

- **I consent to treatment necessary for the care of the above named patient.**
- **I release authorization of records to my physician(s) and to the insurance carrier, if requested.**
- **I allow fax transmittal of my records.**
- **I acknowledge full financial responsibility for services rendered by The Institute for Hand and Upper Extremity Rehabilitation, Inc. I understand co-pay fees are due at the time of service, and that I will be billed for any patient responsibility after payment has been made by my insurance company if my plan indicates such a responsibility. I also understand that supplies, splints (either custom, fabricated, or other types of splints), or assistive devices are often not covered by insurance, and that I will be financially responsible for such costs incurred. Any legal fees and interest for non-payment of services after 4 months of billing will be my responsibility. Further collections will be instituted with a collection fee and interest charged at 1.5% per month.**
- **I will allow voice messages on my telephone by The Institute for Hand and Upper Extremity Rehabilitation Staff.**

I have read and fully understand the above consent for treatment, financial responsibility, release of information, and insurance authorization.

_____ _____

Patient Signature or Responsible Party Date

# Cancellation/No Show Policy

Rehabilitation is a process which requires consistency in treatment. You will typically be scheduled for 2-3 visits per week.

We understand that appointments must occasionally be cancelled. By reading and signing below, you agree to make every effort to telephone and inform us if you need to cancel an appointment and will adhere to the terms of this policy.

You are expected to reschedule any missed appointments within the same week. It is appreciated if you call as soon as possible.

**If you do not show for an appointment, it is expected you reschedule that appointment.**

**If you do not show for more than one appointment, you will be charged $35.00 each time that you do not call and do not show for an appointment.**

**Any unpaid balance over 60 days will be forwarded for collection.**

**I understand the above.**

_____

_
Patient

# Patient Policies

**Patient Responsibility**

- If you need to cancel an appointment, you agree to call as soon as possible and reschedule the appointment within that week if at all possible.
- You agree to make a concerted effort to complete home exercises, including splint wear as instructed or shown to you by your therapist.

**The Use of Modalities**

- Various forms of heat may be used to pre-condition tissue for exercise. They include hot packs, paraffin, fluidotherapy, and possibly whirlpool. It is important that you understand that these forms of heat are utilized according to standards set forth by professional therapy organizations. People, particularly following injury, may find their tolerance to temperature variable. Therefore, you may experience discomfort from heat used, particularly paraffin or hot packs. **It is imperative that you inform the therapist if the heat you are experiencing is uncomfortable or feels like it is burning.** Also, please inform the therapist if you have any sensory changes which may make you less able to perceive burning.
- Ultrasound is another form of heat utilized at times. You will typically feel no effect from the ultrasound, as it heats deeper tissue. Because of the nature of ultrasound, it may cause reaction to certain cellular growth and reproduction. **Therefore, it is imperative that you inform your therapist if you are pregnant or have a history of cancer.**
- Cold packs are occasionally used in therapy. These can occasionally cause burning as well. Please be sure to indicate to your therapist if you are experiencing any intense cold during cold pack application.
- Iontophoresis is sometimes used to treat inflammation due to tendinopathies. This utilizes an electrical charge to drive medication into tissue and may cause an electrical burn. If you feel a burning sensation during this treatment, again, inform your therapist of such.

It is our goal to help and guide you through a positive therapy experience. We take a team approach to treating you and need your cooperation in this effort. Please sign below affirming your agreement to the above statements.

_____ _____

Patient Date

_____

Therapist

# HIPPA Compliance for Privacy Act

It is our legal duty to maintain the privacy of your health information. We are required under federal law to provide you with this notice, and you may request a copy of this notice at any time.

**Disclosures of Health Information**

We use and disclose your health information, including medical reports, reports, and history, for the purpose of payment and healthcare operations. The following includes causes for this:

- **Treatment**: We may use or disclose your health care information to a physician or other healthcare professional providing treatment to you.
- **Payment**: Insurance companies, such as worker's compensation, auto, and some private companies, require information to obtain payment for services.
- You may give permission to disclose health care information to anyone for any purpose by notifying this office in writing. Without such written authorization, no information will be provided to any other group or individual, including family members unless the patient is a minor.
- We will not use your health care information for marketing without your specific written authorization.
- **Required by law**: We may use or disclose your health information when we are required to do so by law.
- **Abuse or neglect**: We may disclose your health care information if it is felt that you are a victim of abuse, neglect, domestic violence, or possibly a victim of other crimes.
- **Appointment scheduling**: A message may be left on a voicemail or answering machine regarding an appointment. This will be only a general message and not include any details regarding your care.

**Patient Rights:**

- **Access**: You have the right to look at or get copies of your records and health information. Photocopies will be provided on request at a charge of $0.30 per page. The request can be made in person or by mail.
- You may request additional restrictions on your health care records, however, there is no guarantee of agreement to the restrictions set forth.
- If you feel that you require additional privacy with the treating therapist or other staff member to ensure your privacy, you are welcome to it. Your request can be made to any staff member regarding this request.

*The Institute for Hand and Upper Extremity Rehabilitation*

## Patient Health History

Patient Name: _____ DOB: _____

Weight: _____ Height: _____ Family Physician: _____

1. Do you smoke? ____Yes ____ No

   If yes, are you interested in ceasing from smoking? ____Yes ____ No

2. Have you fallen once in the past year with an injury, or twice without needing medical attention? ____ Yes ____ No

   Please describe your injury briefly. _____

3. Do you feel safe in your home? ____ Yes ____ No

   If you wish to discuss this in private, please request to do so.

4. Please list your medications or provide a list to the staff. _____

5. Please list any allergies, including latex: _____

6. List all medical illnesses: _____

   _____

   Please circle any of the following if they apply to you:

   Pacemaker Artificial Joint History of Cancer Diabetes Hypertension Arthritis

7. Prior injuries including cervical or neck injury, fractures, etc. _____

8. Over the past few days, what is your least pain level (0 being no pain, 10 being the worst pain ever), and your worst pain level:

| Please circle: | Least Pain Level: | Worst Pain Level: |
|---|---|---|
| | 0 1 2 3 4 5 6 7 8 9 10 | 0 1 2 3 4 5 6 7 8 9 10 |

Please let us know when you are going to the doctor for a follow-up appointment. We communicate with the physician through written report and can provide reports to your physician only when you communicate to us that you are seeing your physician in a timely manner.

In order for the therapist to provide care to you, you must agree to allow medical reports to be sent as needed. Please initial next to each of the following acknowledging your consent to do so.

_____ Primary care physician

_____ Referring physician or physician assistant

_____ Insurance company

_____ Any other physician you request to be informed of your care

_____ Employer, if worker's compensation (optional)

_____ Lawyer (optional)

_____ Collection purposes

_____ Parent

_____ _____

Signature of Client Date

**The Institute for Hand & Upper Extremity Rehabilitation**
**TEXT OPT IN - Appointment Reminders and Promotions**

Name (please print) _____

Cell Phone Number _____

I understand that I am opting in to The Institute for Hand & Upper Extremity Rehabilitation text service, and have read the following terms.

Disclaimer: You agree that by providing your wireless telephone number to The Institute for Hand & Upper Extremity Rehabilitation, you are expressly consenting to receiving marketing text messages to the mobile number provided. Consent is not a requirement to purchase any goods or services. You may receive up to 15 text messages per month for appointment reminders and promotions. Message and data rates may apply. You may reply HELP for help, STOP to stop at any time. We respect your privacy, your information is confidential and is not shared with any third party.

_____ _____

Signature Date