MERIDIAN HAND THERAPY
Patient Information Form

MR. □ MRS. □ MS. □	
NAME:	SPOUSE NAME:
PARENT NAME (If minor):	
ADDRESS - Number & Street Name:	City, State & Zip Code:
HOME PHONE #:	WORK/CELL PHONE #:
EMPLOYER:	OCCUPATION:
ADDRESS - Number & Street Name:	City, State & Zip Code:
SOCIAL SECURITY #:	DATE OF BIRTH:
EMAIL ADDRESS:	
SPOUSE/PARENT EMPLOYER:	Phone #:
ADDRESS – Number & Street Name:	City, State & Zip Code:
SPOUSE/PARENT SS#:	SPOUSE/PARENT DOB:
Date of injury:	
Is this a work related injury? YES □ NO □	
Do you have a lawyer representing you? YES □ NO □	
Please list name of lawyer:	Phone #:
Who is your primary physician?	
Did the physician who issued the prescription for Occupational Therapy refer you to our facility for treatment? ___Yes ___No If the answer is No, please list who referred you to our facility.	
How did you hear about our facility?	
When is your next scheduled appointment with the referring physician?	
List two emergency contacts (nearest relative or friend): Name:_____ Relationship:_____ Phone #_____ Name:_____ Relationship:_____ Phone# _____	

Meridian Hand Therapy

696 Hampshire Road, Suite 180A
Westlake Village, CA 91361
Phone: 805.497.1700 Fax: 805.497.1066

Initial Subjective Report

Name: _____ ***Age:***_____

1. GENDER: Male/ Female HAND DOMINANCE: Left/ Right/ Both (circle one)

2. Please mark diagnoses/conditions you have had (with dates), or currently have:

□ Hepatitis	_____	□ Diabetes	_____	□ Seizures	_____
□ High blood pressure	_____	□ Cancer	_____	□ Immune deficiency	_____
□ Heart disorder	_____	□ Arthritis	_____	□ Dizzy spells	_____
□ Circulation disorder	_____	□ Osteoporosis	_____	□ Other	_____

3. Please list SURGERIES/ recent DIAGNOSTIC STUDIES (MRI, X-rays) you have undergone (procedure and date): _____

4. Do you have METAL (pins, plates, pacemaker) anywhere in your body? (other than your teeth).
NO YES Please indicate where: _____

5. For women: Are you currently PREGNANT? NO YES Months of Pregnancy_____

6. Please list any known ALLERGIES: _____

7. Have you recently taken STEROIDS or ANTI-COAGULANTS for an extended period of time?
NO YES_____

8. Have you had physical therapy treatments before? If yes please indicate where, when and for which problem:_____

9. Briefly describe the history of your present ACCIDENT, INJURY OR ILLNESS:
Onset date:_____ Description:_____

10. Please indicate where your pain is located and circle the range of pain you are experiencing for each body area: (**0** equaling no pain and **10** being equivalent to pain requiring hospitalization).
1. _____ **0 1 2 3 4 5 6 7 8 9 10** 2. _____ **0 1 2 3 4 5 6 7 8 9 10**

11. Is there ever a period without pain? YES NO **(please circle NO only if pain is constant, occurring without movement and during sleep)**

12. How would you best describe your pain? Dull_____ Aching_____ Stabbing____
Grabbing_____ Burning_____ Radiating_____ Other_____

13. Please indicate when your pain is greatest: First thing in the morning____ During the day_____
At the end of the day_____ During sleep_____ Constant _____

14. What other symptoms are you experiencing? Stiffness__ Weakness__ Numbness__ Other___

15. Are you medicating for pain, swelling or muscle spasms? YES NO Medications:_____

16. What aggravates your symptoms? _____

17. What eases your symptoms? _____ (medications, positions, etc..)

18. What activities are you limited in or unable to perform? _____
_____

Patient's Signature_____ Date: _____

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Medication List

Name: _____

Please fill in your medications with dosage below and continue on the back as needed. We also request that you update your therapist on any changes throughout the course of your treatment.

MEDICATION	DOSAGE	FREQUENCY

Signature:_____ Date:_____

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INSURANCE INFORMATION

Health and accident policies are an arrangement between you and your insurance company. You are personally responsible for all services rendered in our office. As a courtesy, our office will bill your primary insurance. All unpaid charges will be billed directly to you, the patient. We accept assignment of benefits. Your insurance company will send payment directly to our office. Should your insurance company send you payment for our services; you will be responsible to reimburse Meridian Hand Therapy, Inc. We will promptly credit all received payments from your insurance company. *Please also be aware that some insurance policies have a maximum number of visits they will allow per calendar year and that these may be combined with physical therapy, chiropractic care, speech therapy, and/ or acupuncture. If these visits have been used, you will be financially responsible.*

Patient name (print): _____ Insurance Company: _____

Our office will not enter into a dispute between you and your insurance company over claims. This is your responsibility and obligation. _____ **(Patient initials)**

PRIVATE & MEDICARE INSURANCE – The fees charged in our office are comparable to those charged by other occupational therapists in this area with similar qualifications.

***MEDICARE* –** In order for your Medicare benefits to apply, you must see your doctor every 30 days and obtain a new prescription for occupational therapy. You are responsible for obtaining this prescription from your doctor. Please note: if your doctor is not a Medicare provider, you may be financially responsible for the cost of any supplies issued. You are also responsible to notify our office if you are receiving home health services. Medicare will not pay for services rendered by our office if you are receiving home health services at the same time. If you do receive our services and are also receiving home health services you will be financially responsible.

ARE YOU CURRENTLY RECEIVING HOME HEALTH? PLEASE CHECK: YES___ NO____

IS MEDICARE AWARE THAT YOU HAVE A SECONDARY INSURANCE? PLEASE CHECK: YES___ NO____

WORKER'S COMPENSATION – If you are hurt on the job, your employer's workers compensation will pay 100% of your care upon authorization from the adjuster. Please be advised that if your case is not accepted and authorized, you will be responsible for the entire balance. Payment will be due in full immediately.

PERSONAL INJURY/AUTO ACCIDENT – If you have Med-pay coverage on your automobile policy, we will bill them for prompt and direct payment. Med-pay will cover your doctor bills regardless of who was at fault. If there is no Med-pay coverage, we will bill your health insurance. Liens will only be taken on a case by case situation.

My signature below states that I have read, and have been informed of my insurance benefits, as quoted by my insurance company. I am aware of my financial responsibility to Meridian Hand Therapy. I understand and agree to the above terms and conditions.

Patient signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES Office Manager, Privacy Officer, 805-497-1700

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature: _____ Date: _____
Print Name: **_____ Telephone: _____**

If not signed by the patient, please indicate relationship: **___ Parent or guardian of minor patient ___ Guardian or conservator of an incompetent patient ___ Beneficiary or personal representative of deceased patient**

Name of Patient: _____

MERIDIAN HAND THERAPY CANCELLATION POLICY & ADDITIONAL CHARGES

In order to ensure appointment times for each of our patients, we will enforce a **$45.00 cancellation fee** for appointments that are not cancelled at least 24 hours **before the scheduled time**. This fee will be applied to each missed appointment and must be paid by the patient**. (Your insurance company will not cover this charge).**

Cash Patients: $150.00 for the initial evaluation and $95.00 per session thereafter plus the cost of supplies is the discounted cash rate for patients without insurance.

Returned check charge: $15.00 per check

Late payment charge: $10.00 or 1.5% (whichever greater) will be added to your account along with a collection service and/or attorney fees for delinquent accounts. There will be a $15.00 office charge for the copying of medical records.

I am aware of my financial responsibility to Meridian Hand Therapy. I understand and agree to the above terms and conditions.

Patient signature: _____ Date: _____

Meridian
Hand Therapy

Patient's Name: _____ Date: _____

Your insurance company may not pay for the item(s) or service(s) that are described below. Most insurance companies do not pay for all of your health care costs. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be good reason for your doctor/therapist to recommend it. Right now, in your case, **your insurance company may not pay for**:

- Iontophoresis pads
- Iontophoresis treatment
- Dressing change supplies
- Silicon gel
- Tape/ Coban
- Home exercise equipment
- Wound debridement
- Theraputty
- Tubigrip
- Stockinette
- Electrodes
- Digisleeve
- Ice packs

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have it pay for them yourself. Before you make a decision you should read this entire form.

- Ask us to explain, if you don't understand why your insurance company might not pay.
- Ask us how much these items or services will cost you in case you have to pay for them yourself.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN AND DATE YOUR CHOICE.

☐ Option 1: **YES**, I want to receive these items or services.
I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. If my insurance company denied payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.

☐ Option 2: **NO**, I have decided not to receive these items or services.
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company won't pay.

_____ _____
Date Signature of patient or person acting on patient's behalf

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Wound debridement Iontophoresis pads Dressing change supplies Silicon gel/sleeve Tape/Coban Home exercise equipment Theraputty Tubigrip Electrodes Digi Sleeve Ice packs	Not covered	$5-$100

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Date:_____

UPPER EXTREMITY FUNCTIONAL INDEX

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with: (Circle one number on each line)

ACTIVITIES	Extreme Difficulty	Quite a bit of Difficulty	Moderate Difficulty	A Little bit of Difficulty	No Difficulty
a. Any of your usual work, housework or school activities	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Lifting a bag of groceries to waist level	0	1	2	3	4
d. Placing an object onto, or removing it from an overhead shelf	0	1	2	3	4
e. Washing your hair or scalp	0	1	2	3	4
f. Pushing up on your hands (e.g., from bathtub or chair)	0	1	2	3	4
g. Preparing food (e.g., peeling, cutting)	0	1	2	3	4
h. Driving	0	1	2	3	4
I. Vacuuming, sweeping, or raking	0	1	2	3	4
j. Dressing	0	1	2	3	4
k. Doing up buttons	0	1	2	3	4
l. Using tools or appliances	0	1	2	3	4
m. Opening doors	0	1	2	3	4
n. Cleaning	0	1	2	3	4
o. Tying or lacing shoes	0	1	2	3	4
p. Sleeping	0	1	2	3	4
q. Laundering clothes. (e.g., washing, ironing, folding)	0	1	2	3	4
r. Opening a jar	0	1	2	3	4
s. Throwing a ball	0	1	2	3	4
t. Carrying a small suitcase with your affected limb	0	1	2	3	4
Column Totals:					

Minimum level of detectable change (90% confidence): 9 points

Score: _____ / 80

NOTICE AND AUTHORIZATION TO COMMUNICATE BY EMAIL, TEXT MESSAGE AND OTHER NON-SECURE MEANS

Patient Name: _____ Date of Birth: _____

Patient Email Address: _____

Meridian Hand Therapy, Inc. and its staff cannot guarantee the security and confidentiality of an e-mail transmission. Employers and on-line services have the right to access and archive e-mail transmitted through their systems. If your e-mail is a family address, other family members may see your messages, therefore, please be aware that you e-mail at your own risk. Because of the many internet and email factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail. Your health care provider is not liable for breaches of confidentiality caused by yourself or a third party.

E-mail is best suited for routine matters and simple questions. You should not send us e-mail for urgent or emergency situations or for matters requiring an immediate response. Your provider will attempt to read and respond promptly to e-mail but cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone.

Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

Please include your full name, birthdate and telephone number in all e-mails. List the subject of your e-mail in the "Subject" line of your message.

All e-mails between you and your provider regarding diagnosis or treatment will be printed and made part of your permanent health information.

Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the health care team without your authorization.

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. All these methods of communication are non-encrypted and therefore not considered fully secure, and do not meet the security requirements set forth by the Health Insurance Portability and Accountability Act (HIPAA). These methods, in their typical form, are not confidential means of communication. There may be some level of risk that your private medical information in email could be read by a third party. Unauthorized access of protected health information while in transmission to you may occur.

There is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages.

Phone and fax are considered more secure. However, because of their extreme convenience and wide availability, these non-secure methods are offered as an additional means of communicating with Meridian Hand Therapy, Inc. and its staff.

Meridian Hand Therapy, Inc. and its staff are not responsible for safeguarding information once delivered to you. You are responsible for protecting your password or other means of access to e-mail.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I authorize and consent to allow **Meridian Hand Therapy, Inc. and it staff** to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

1) Information related to the scheduling of meetings or other appointments;
2) Information related to billing and payment;
3) Medical records and reports.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time. This agreement expires one year following the last date of service.

_____ Date: _____
Signature of Patient

_____ Date: _____
Witness

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, an paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information:
We may use .and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions an certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775