DESERT HAND AND PHYSICAL THERAPY PATIENT DATA SHEET

DO NOT EMAIL This electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

_____

_____

_____

_____

Mailing Address:

_____

_____

_____

Phone Numbers:	**OK To Call**	**Best Time To Call**
Home: _____	☐	_____
Work: _____	☐	_____
Cell: _____	☐	_____

May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

☐ Yes ☐ No

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: _____

Preferred language: _____ **Interpreter required?** ☐

Date of Injury: _____ **Referring Physician:** _____

Injury Area: _____ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

PATIENT EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

SPOUSE EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other _____

Specify if other : _____

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Patient **Date**

Desert Hand and Physical Therapy
PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
Desert Hand and Physical Therapy
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:** _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
Initials: _____

LIABILITY

I know and agree that: Desert Hand and Physical Therapy
is not responsible for loss or damage to personal valuables. **Initials:** _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: Desert Hand and Physical Therapy
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.
Initials: _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: Desert Hand and Physical Therapy
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices.
Initials: _____

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials: _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:** _____
I acknowledge receipt of the Statement of Patient Rights. **Initials:** _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

DESERT HAND AND PHYSICAL THERAPY

MEDICAL HISTORY

Patient Name:_____ **Date:** _____

Date of injury/ onset: _____ **Date of surgery**: _____

What side of the body are we treating today? Right Left Both Other

How did your injury happen? _____

Do you have any open cuts, lesions or wounds? Yes No If yes, where? _____

Accident Related? Auto ____ Work ____ Other ____ Are you Right or Left Handed? _____

Occupation: _____ Working _____ Off Work _____ Light Duty _____

Reason for attending therapy: (check all that apply): Motion ____ Weakness ____ Pain: 0 1 2 3 4 5 6 7 8 9 10

What specific activities are most difficult because of your problem?

1._____ 2._____

Do you use tobacco: (check one): Yes _____ No_____ If so how much? _____

Current Medications -dosages and frequency (required for Medicare):

Name of Medication	Dosage	Amount	How Often
1			
2			
3			
4			
5			

Allergies:_____ **Are you allergic to Latex?** Yes_____ No_____

Wear glasses/contacts? YES ___ NO ___ Any previous injuries to this extremity? _____

Have you fallen in the past year? YES _____ NO _____ If Yes, How many times? _____

Did you sustain any injuries as a result of the fall? YES NO

Have you ever had any of the following conditions? (Circle all that apply)

Anemia Depression Hepatitis HIV Currently Pregnant Stroke Asthma

Kidney Problems Dizziness/Fainting Tuberculosis Cancer Fractures Epilepsy

Respiratory Problems Substance abuse Insomnia Headaches Diabetes Seizures

Metal Implants Pacemaker Osteoporosis Low Blood Pressure High Blood Pressure

Cardiac problems Rheumatoid Arthritis Osteoarthritis Thyroid Problems Multiple Sclerosis

Any other medical problems? _____

TREATMENT CONSENT

The nature of your treatment, the risks, the possible interventional alternatives and treatment goals have been discussed with you. Also, your medical history has been reviewed by the therapist to assist them in your evaluation and assessment. I agree that DH&PT may provide medical information regarding this injury to my primary care physician, in addition to my referring physician.

Patient Signature: _____ Date: _____ Therapists Initials _____

Published
May 2019

DESERT HAND AND PHYSICAL THERAPY

CONSENT TO USE OF LIKENESS AND TESTIMONIAL AND RELEASE

I, _____, hereby consent to allow Desert Hand and Physical Therapy and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

_____ _____

Participant Name Date

_____

Parent/Legal Guardian (If Participant is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I,_____, hereby consent and authorize Desert Hand and Physical Therapy and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

_____ _____

Participant Name Date

_____

Parent/Legal Guardian (If Participant is a Minor