Hand Rehabilitation Specialists

WELCOME TO HAND REHABILITATION SPECIALISTS

We are a therapist-owned private-practice clinic in Thousand Oaks and Simi Valley. Our professional staff includes Certified Hand Therapists, Physical Therapists and Occupational Therapists with combined experience exceeding over 80 years. We pride ourselves in providing the most updated and quality treatment to our clients. All therapists are trained to treat a multitude of injuries including orthopedic, traumatic, reconstructive, and repetitive strain injuries.

Thousand Oaks Office Hours
101 Hodencamp Rd. # 100
Thousand Oaks, CA 91360
(805) 495-0516

Monday	8:00 - 6:30
Tuesday	8:00 - 6:30
Wednesday	8:00 - 6:30
Thursday	8:00 - 6:30
Friday	8:00 - 6:30

Simi Valley Office Hours
3695 Alamo Str. # 205
Simi Valley, CA 93063
(805) 520-7990

Monday	8:00 - 6:30
Tuesday	8:00 - 6:30
Wednesday	closed
Thursday	8:00 - 6:30
Friday	8:00 - 6:30

In general, we recommend scheduling ongoing appointments for two weeks in advance.

IMPORTANT:

We do require **24 hour notice** of cancellations. If you are unable to cancel within the required 24hrs you will be responsible for the cancellation/missed appointment fee of $ 45.00. If you need to cancel an appointment after hours, you may leave a message on our voicemail system (805) 495-0516.

Supplies issued in the clinic such as putty, sterile wound dressings, splints etc. may not be covered by insurance; you will be responsible for any charges. Co-payments, which your insurance may require, are due at the time of each office visit, preferred payment methods are Cash or Check. Thank you.

At your first appointment, all insurance information is gathered and insurance authorization is obtained as soon as possible. If we are unable to reach your insurance company or obtain necessary authorization we will inform you.
Please do not wear perfumes or aftershaves during your therapy sessions, out of consideration for our patients with allergies sensitivities.

We strive to make your experience at Hand Rehabilitation the most positive on your journey to better health. If you have any questions or concerns, please feel free to let your therapist know.

Thank you.

Heidi Bowers-Dutra OTR/L, CHT
Laurie Roundtree, OTR/L, CHT
Eileen Seiberlich, OTR/L, CHT
Adrienne Yin, MPT, CHT
Melissa Johns, MSPT

Rev. 04/20/2020

Hand Rehabilitation Specialists

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that under the HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse who is involved with your insurance claims fulfillment.

Under these new regulations the following people must be authorized by you to have access to your health information: your spouse, other family members, and friends; nurse or home aid; legal guardian; or other person/organization who is not involved with your medical treatment, insurance plan, or payment.

1. INDIVIDUAL PATIENT

I give my authorization to use or disclose my protected health information as described in section 2 below.

Name: _____ DOB: _____

Legal Responsibility

☐ If you are 18 years old or older, you are legally responsible for yourself; check this box.
☐ If you are an emancipated child or teenager and your patents no longer have custody over you, check here.
☐ If you are a child or teenager and your parents are divorced, please check this box. Below please list the name(s) of your Custodian(s): _____

2. PEOPLE or ORGANIZATIONS WHICH I AUTHORIZE TO HAVE ACCESS TO MY INFORMATION:

1) Name _____ Contact Phone:_____

Address:_____ Relationship to the Patient:_____

2) Name _____ Contact Phone:_____

Address:_____ Relationship to the Patient:_____

3. CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer.

4. METHOD OF CONTACT

I authorize the office of The Hand & Upper Extremity Centers (dba Hand Rehabilitation Specialists) to contact me the following manner:

	Ok to leave detailed message (please mark Yes or No)	Ok to leave call back number only (Please mark Yes or No)	Ok to Fax (please let us know Fax Number)
Home Phone	□Y □N	□Y □N	
Mobile Phone	□Y □N	□Y □N	
Work Phone	□Y □N	□Y □N	
Ok to mail to Home Address	□Y □N		
Ok to mail to Work Address	□Y □N	If Yes please let us know your Work Address:	

5. STATEMENT OF UNDERSTANDING

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates of the Hand & Upper Extremity Centers (dba Hand Rehabilitation Specialists) who are part of the health care process. These business associates will also keep your health information confidential.

Signed by Patient: _____ Date: _____

Signed By Patient's Representative (if applicable):_____ Date: _____

Description of Representative's Authority _____

Health History

Have you ever had:	*Circle*	*Please describe*
Auto accidents, prior injuries	yes no	_____
AIDS, HIV……..	yes no	_____
Arthritis/Lupus/Gout/Rheumatoid/Osteoarthritis	yes no	(Please specify which):_____
Bleeding tendency……..	yes no	_____
Blood clots, current or past (incl. phlebitis, emboli)	yes no	_____
Cancer or tumors, past or present, incl. skin…	yes no	_____
Depression, anxiety or other psych. disorders	yes no	_____
Diabetes (PLEASE SPECIFY Type I, Type II, Insulin Dependent)	yes no	_____
Epilepsy or convulsions…….	yes no	_____
Fibromyalgia..... ……..	yes no	_____
Fractures/broken bones (excl. current referral)	yes no	_____
Head injury, Alzheimer's, Senility, Dementia	yes no	(Please specify which):_____
Heart problems of any sort……	yes no	_____
Pacemaker……	yes no	_____
Hepatitis; Renal Failure..……	yes no	_____
High blood pressure, low blood pressure…	yes no	_____
Implanted NEUROSTIMULATION device	yes no	_____
Light-headedness, fainting, seizures…….	yes no	_____
Neck or back pain/disorders……	yes no	_____
Chronic Regional Pain Syndrome/RSD…….	yes no	_____
Peripheral vascular disease/Raynaud's……	yes no	_____
Peripheral neuropathy	yes no	_____
Pulmonary disease, incl. COPD, emphysema	yes no	_____
Recent illness, hospitalization……..	yes no	_____
Scar problems (keloids, etc)……..	yes no	_____
Skin hypersensitivity to light.....	yes no	_____
Stroke……	yes no	_____
Tuberculosis…….	yes no	_____
Are you currently pregnant or breastfeeding?	yes no	_____
Other health issues not listed……..	yes no	_____

SMOKING: ☐ ___ packs a day ☐ quit but smoked for ___ years. _____

SURGERIES: Please list previous relevant surgeries(arms, neck, shoulder, back) and their approximate dates:

_____

_____

MEDICATIONS: _____

_____

_____

ALLERGIES: (medications, sulfur, adhesive tape, latex, etc)_____

_____

RECREATION: activities, sports, hobbies:_____

_____

WORK: Occupation:_____Job Tasks:_____

Which is your dominant hand (please circle): right left

Signature:_____ Today's date:_____

HAND REHABILITATION SPECIALISTS - PATIENT INFORMATION

Patient Name *(per Insurance Card - please print)*

First Name: _____ *Middle Initial:* _____ *Last Name:* _____ *DOB:* _____

SSN#	Marital Satus: ☐single ☐married	Sex: F☐ M ☐
Home Phone:	Cell:	E-mail:
Address: Street: _____ City: _____		State: _____ Zipcode: _____
Employer:	Position:	
Employer Address:		Phone #
If patient is minor or other reason: Guardian Information: Mom ☐ Dad☐ Both ☐ Other ☐		
Address of Guardian:		Phone #
Power of Attorney: Name		Phone #
Power of Attorney: Address		

MEDICAL CONDITION

CONDITION FOR WHICH YOU ARE SEEKING TREATMENT: _____

Please circle: right left bilateral(both sides)	Did you have surgery? Y ☐ N ☐ If Yes - Date of Surgery:
Your Physicians Name and City please:	
Your Medical Condition is result of (please circle appropriate answer) Work Injury Accident Auto Accident Other	
Date Condition/Injury began:	Do you have an attorney? Y ☐ N ☐
If Yes please provide Attorney's Name and Telephone Number: Name:	Phone#

INSURANCE

Insured Party: self ☐ other ☐	Subscriber Name:
Subscriber's DOB:	If other please state Name:
If other please state relationship to patient:	if other: DOB
Workers Comp Insurance : Y ☐ N ☐	
If yes, has a claim been filled out at your work? Y ☐ N ☐ If not are you planning to? Y ☐ N ☐	

EMERGENCY CONTACT

Name:	Relationship:	Phone#
Name:	Relationship:	Phone#

AUTO ACCIDENT/INCIDENT

If your injury is due to an Auto Accident, or anything that Auto insurance handles, please provide the following information:

*Your auto insurance has determined following(please circle): at fault no fault - other driver

(*Pls note: Mark at fault if you are contesting or going into litigation)

Do you have Medpay(Medical Coverage through YOUR Car Insurance - usually it costs extra and details are on your policy) Y ☐ N ☐

****If you do not know, or are unsure, please look at a copy of your policy or call your Insurance agent to find out ****

Most health insurance plans require that billing is submitted to them AFTER Medpay has been billed along with a copy of the payment details. Most plans will place all claims on hold until they know your Medpay status. They may send a letter to you requesting proof of non-coverage even if you do not have Medpay. That is usually either a letter from your car insurance company stating that you do not have Medpay or a copy of your policy sent to them.

****If you have Medpay on your Autopolicy please complete information required below:

Name of Auto Insurance Company:	Claim#
Date of Accident:	Contact Information:
Phone#	Fax#

****Your Auto Insurance may require that you fill out an Assignment of Benefits form to be able to process our claims and remit payments to us. We can only accept a medpay policy if claims are paid to us directly. Thank you!****

HOME HEALTHCARE

Do you currently have Home Health Services of any kind which your insurance provides to you (including IV Placements, Blood Pressure monitoring, etc) where a medical professional comes to your home, regardless of the amount of time they spend with you, reason or frequency of visits Yes ☐ No ☐

Please note: If yes to Home Health Services, we cannot currently provide any treatment other than providing splints until Home Health Services have ended and a copy of Discharge is provided.

Home Health Services Name:	Phone#

THERAPY WITHIN CURRENT YEAR

Have you had any Therapy this year for any reason - even if not related to your current diagnosis?

Occupational Therapy: Y ☐ N ☐ Physical Therapy: Y ☐ N ☐ Chiropractic : Y ☐ N ☐

If you stopped when did you stop receiving treatment? _____

If yes, how many visits exactly _____ were used. If you do not know, or are unsure, AND your insurance plan has a visit maximum, we kindly ask that you call the prior place(s) to get your amount used. This is so that we can help you avoid denials and payments out of your pocket for services rendered.

Are your <u>currently</u> being treated for OT or PT (for any body part) OR plan on starting while with us? Y ☐ N ☐

If yes, what type of therapy (please circle which one applies): Occupational Therapy: ☐ Physical Therapy: ☐ Chiropractic : ☐

*** Please note: many insurances do not allow treatment on the same day even if it is at different locations and for different reasons, especially, if both providers are P.T's. Please ask front office to book you on alternate days if receiving therapy elsewhere.

***Also, if your insurance policy separates the PT from the OT visit count and you are, or plan to, receive PT for anything else, please let our Medical Receptionists know. Thank you.

GENERAL INFORMATION

How did you hear about us? Self☐ MD ☐ Ins. (In-Network) ☐ Friend ☐ Internet ☐ Other Professionals☐ Workers Comp

If your Physician referred you please provide Physician's name and Office Location (City only)	

Who should we thank for this referral?

PATIENT SIGNATURE

Please read the following and sign: I hereby authorize payment of medical services rendered to me or my dependent directly to Hand Rehabilitation Specialists (HRS). I also authorize HRS to furnish my insurance company (or its representative) with full information regarding evaluation and treatment rendered to my or my dependent. A photocopy thereof shall be valid. I also consent to being examined and treated at Hand Rehabilitation Specialists. **I acknowledge that I have received notification of this office's Privacy Practice. Initials:**

_____

Cancellation/NO SHOW Policy: ***I understand that all appointments cancelled without 24 hour advance notice as well as NO SHOWS for appointments incur a $ 45.00 charge, which I am responsible for and which is not billable to my insurance. I also understand that if I miss two appointments without prior notification, all future appointments will be cancelled and I will have to reschedule, possibly losing a preferred time slot.*** ***INITIALS: _____ Date:***

Please read the following and sign (except workers comp patients): I understand that my insurance company is billed as a courtesy and that I am responsible for all charges not paid by my insurance. I also understand that therapy supplies and splints may not be covered by my insurance, and I will be responsible for payment at the time supplies are provided. I will therefore ask the therapist the cost of any supplies provided. I understand that HRS will bill my insurance for these items and reimburse me if payment is received.

Signature:	Date: