CAPE COD HAND & UPPER EXTREMITY REHABILITATION PATIENT DATA SHEET

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? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

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?** ☐ Yes

Date of Injury: **Referring Physician:**

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

State Where Accident Occured:

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

Employer: **Occupation:**

Address:

Phone:

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

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: CAPE COD HAND & UPPER EXTREMITY REHABILITATION 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:CAPE COD HAND & UPPER EXTREMITY REHABILITATION is not responsible for loss or damage to personal valuables.

Initials: _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: CAPE COD HAND & UPPER EXTREMITY REHABILITATION 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: CAPE COD HAND & UPPER EXTREMITY REHAB
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** _____

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of CAPE COD HAND & UPPER EXTREMITY REHABILITATION. This form must be completed in its entirety and must be provided to CAPE COD HAND & UPPER EXTREMITY REHABILITATION prior to initiation of therapy services. **Revised 4.5.21**

Medical History Form

Patient Name:	**Today's Date:**	
Referring Physician:	**Date of Birth:**	**Age:**
Primary Care Physician:	**Are You Presently Working**? ☐ Yes ☐ No	
Date of Next Physician Appointment:	**Date of Injury or Onset:**	

Reason for Therapy:

Cause of Injury or Onset: ☐ Accident ☐ Auto ☐ Work ☐ Other: **If Other, please explain**:

Have you been hospitalized for the present condition? Yes ☐ No **If Yes, date**:

Did you have surgery for this condition? ☐ Yes ☐ No **If Yes, date**:
If Yes, surgery type:

Are you currently receiving any other care for the condition mentioned above? ☐Yes ☐No
If Yes, please describe:

Have you ever received therapy in the past for the condition mentioned above? ☐Yes ☐ No **If Yes, date:**
Describe previous treatment:

Previous Treatment: ☐Successful ☐Unsuccessful

Have you fallen in the last year? ☐ Yes ☐ No **If Yes, how many times?** **If Yes, were you injured?** ☐ Yes ☐ No
Do you feel unsteady when standing or walking? ☐ Yes ☐ No **Do you worry about falling?** ☐ Yes ☐ No

What are your personal goals/outcomes you hope to achieve from therapy?

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Do you smoke or use tobacco?** ☐ Yes ☐ No

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ **Allergies** ☐ **Latex** ☐ **Other**	☐ **Dizziness**	☐ **Kidney Problems**
☐ **Anemia**	☐ **Epilepsy or Seizure Disorder**	☐ **Metal Implants**
☐ **Anxiety or Panic Disorders**	☐ **Fainting**	☐ **MRSA**
☐ **Arthritis** ☐ **OA** ☐ **RA**	☐ **Fatigue or Weakness**	☐ **Multiple Sclerosis**
☐ **Asthma**	☐ **Fever or Chills**	☐ **Nausea / Vomiting**
☐ **Blood Thinners**	☐ **Fractures**	☐ **Osteoporosis**
☐ **Bowel or Bladder Disorder**	☐ **Headaches**	☐ **Pacemaker**
☐ **Bleeding Disorder**	☐ **Head Injury or Concussion**	☐ **Parkinson's Disease**
☐ **Cancer**	☐ **Hearing Impairment**	☐ **Peripheral Vascular Disease**
☐ **Chronic Cough**	☐ **Heart Disease or Heart Attack**	☐ **Respiratory or Breathing Problems**
☐ **COPD**	☐ **Hepatitis** ☐ **A** ☐ **B** ☐ **C**	☐ **Ringing in Ears**
☐ **Congestive Heart Failure**	☐ **Hernia**	☐ **Sexual Dysfunction**
☐ **Currently Pregnant**	☐ **Blood Pressure** ☐ **High** ☐ **Low**	☐ **Skin Abnormalities**
☐ **Deep Vein Thrombosis (DVT)**	☐ **HIV or AIDS**	☐ **Stroke or TIA**
☐ **Depression**	☐ **Hypoglycemia**	☐ **Thyroid Problems**
☐ **Diabetes** ☐**Type I** ☐ **Type II**	☐ **Hypersensitivity to Hot or Cold**	☐ **Tuberculosis**

List any other medical problems and explain:

Over the Counter Medications (check all that apply): ☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine:
☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills ☐ Vitamins/Herbal Supplements ☐ Other:

Medical History Form

Name of Medication	Dosage	Frequency	Route
1			☐ Injection ☐ Oral ☐ Topical ☐ Other
2			☐ Injection ☐ Oral ☐ Topical ☐ Other
3			☐ Injection ☐ Oral ☐ Topical ☐ Other
4			☐ Injection ☐ Oral ☐ Topical ☐ Other
5			☐ Injection ☐ Oral ☐ Topical ☐ Other
6			☐ Injection ☐ Oral ☐ Topical ☐ Other
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other

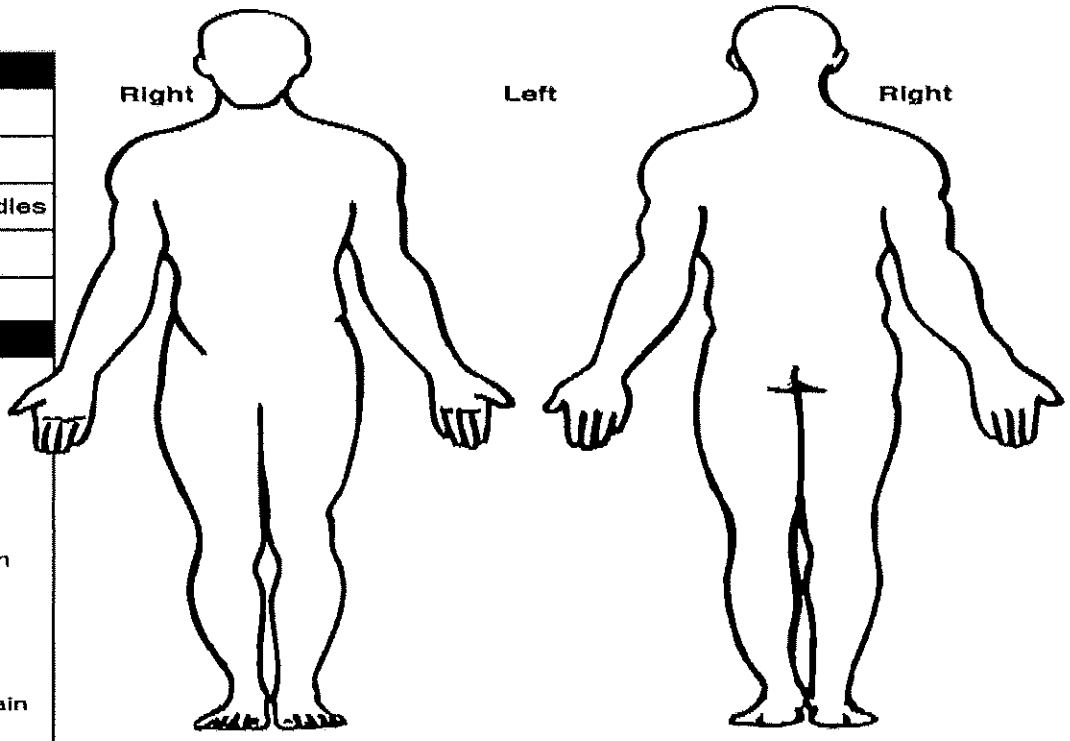
Over the Counter Medications (check all that apply):
☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine: ☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills
☐ Vitamins/Herbal Supplements ☐ Other:

☐ RIGHT HANDED
☐ LEFT HANDED

KEY	
///////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL

0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; It may make you contemplate suicide



CIRCLE YOUR CURRENT PAIN LEVEL
0 1 2 3 4 5 6 7 8 9 10

Have you recently traveled outside the United States? ☐ Yes ☐ No If Yes, date retuned to US: If Yes, list the country(ies) visited:	
Signature of Patient:	
Printed Name of Patient:	**Date:**
Signature of Therapist:	**Date:**

Patient Missed Appointment Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes seriously.

Because we care about you and your progress in therapy, we emphasize the importance of your own commitment to the care you receive at our clinic. Your dedication to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that should be followed in order to ensure the most optimum results.

We expect you keep all your appointments or to provide adequate notice of your intent to reschedule your appointment. We will print and provide to you a card showing the time of your visits so that you do not forget your appointment time.

With the exception of a serious emergency, we expect you to keep all your appointments. **If you need to reschedule an appointment, please provide us with 24 hours notice.** Please call our office and arrange for a make-up appointment with our Front Desk Receptionist. To maintain your therapy schedule and ensure optimal results of your therapy, your make-up appointment should be the same week, preferably the day following your original appointment.

In cases of repeated non-compliance with your scheduled visits, we reserve the right to discontinue your care with a reasonable amount of notice to you so that you may locate another therapist to continue your care. We will also inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

Thank you for your understanding concerning this matter.

We appreciate your faith in us and strive to accomplish wonderful results and success for you.

CAPE COD HAND THERAPY
CRAIG JORDAN, MS, OTR/L, CHT, CLINIC DIRECTOR

I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND AGREE TO ADHERE TO THE POLICY:

SIGNATURE : _____ DATE : _____

Printed Name: _____