2 Thumbs Up Hand Therapy
Patient Information

Patient Name:_____ Date:_____

Next MD Visit:_____

How did you hear about us?:_____

Please indicate with a check, if you have had any of these:

Allergies
□ Anemia
□ Arthritis/Joint Pain
□ Asthma
□ Blurred Vision
□ Breathing Problems
□ Cancer, Type_____
□ Chest Pain
□ Clotting/Bleeding Problems
□ Depression
□ Diabetes
□ Dizziness/Fainting
□ DVT/Blood Clots/Phlebitis
□ Emphysema
□ Fevers
□ Fractures/Broken Bones
□ Gout
□ Headaches
□ Hearing Loss
□ Heart Disease/Attack
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HTY Disease
□ Kidney/Urinary Problems
□ Lyme Disease
□ Memory Loss
□ Neck or Back Problems
□ Osteoporosis
□ Rashes
□ Seizures
□ Stroke/CVA
□ Swelling of Arms/Legs
□ Thyroid Disease
□ Tuberculosis
□ Ulcers/Reflux
□ Unplanned Weight Loss
□ Other _____

List all operations you have had with an approximate date:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Please list any medications you are currently taking:

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

_____ _____
Patient Signature Date

_____ _____
Parent/Guarantor Signature Date

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PATIENT RESPONSIBILITIES – PLEASE READ AND SIGN

Referrals/Prior Approvals (if applicable): I understand my insurance company will not reimburse for the cost of today's services without a referral/prior approval and I am responsible for payment of the office visit charge or any other charges I may incur.
Co-pay (if applicable): I understand that co-pay amounts are part of the agreement that I have with my insurance company and are due at the time of each visit and that I am responsible for that payment.
Deductible (if applicable): I understand that I have a calendar year deductible for outpatient therapy as outlined in my insurance policy. I understand that I am responsible for any balance that my insurance company does not cover but has been applied to my deductible.
Co-Insurance (if applicable): I understand that I have a co-insurance responsibility as outlined in my insurance policy and that I am responsible for any co-insurance balance as set forth by my insurance company.
Authorization to pay benefits to the provider: I hereby authorize payment directly to the provider for medical benefits and otherwise payable to me for services as described, realizing that I am responsible to pay for non-covered services.
Workers' Compensation Information (if applicable): I understand that it is my responsibility to provide all workers' compensation billing information at the time of the initial visit. I realize that without this information, I will be responsible for any charges incurred at the time of the visit. I understand that my health insurance information will be provided and benefits will be utilized in the event that my workers' compensation claim is denied.
Motor Vehicle Information (if applicable): I understand that it is my responsibility to provide all claim information associated with my motor vehicle accident at the time of the initial visit. I realized that without this information, I am responsible for any charges incurred at the time of the visit. I understand that my health insurance information will be provided and benefits will be utilized in the event that my PIP is exhausted.
Cancellations/No Shows: In order to give all out patients the time and care they need for each treatment, we must follow the schedule. Please be on time for all appointments, and call ahead if you need to cancel an appointment. Consistent lateness and/or missed appointments will result in cancellation of treatment.
We require 24 hours notice for cancellations. (exceptions: weather, sudden illness, emergencies)
We no longer tolerate no show appointments. If 3 appointments are missed, you will be taken out of the schedule and your doctor will be notified.

Please notify us of any changes with your insurance status during treatment. Thank You.

I have read and understand all of the preceding information and certify the information provided is true and correct to the best of my knowledge.

_____ _____
Signature Date

_____ _____
Parent/Guardian Signature Date

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Receipt of notice of PRIVACY PRACTICES written acknowledgment form.

I, _____ acknowledge that I have seen the Notice of Privacy
Print Name

Practices and received a copy.

_____ _____
Signature Date