PATIENT INFORMATION SHEET

PATIENT NAME: _____ **DATE OF BIRTH:** _____

HOME ADDRESS: _____ **CITY:** _____ **ZIP:** _____

CELL PHONE: _____ **HOME/WORK PHONE:** _____

SOCIAL SECURITY NUMBER: _____ **DRIVER'S LICENSE #:** _____

EMAIL: _____

OCCUPATION: _____ **EMPLOYER:** _____

_____

EMPLOYER STATUS (circle one): Not employed Full time Part time Student (FT/PT) Retired

FOR MEDICARE PATIENTS:

HEIGHT: _____ **WEIGHT:** _____

Have you fallen within the last year that resulted in an injury? ___ **Yes** ___ **No**

NATURE OF INJURY: ☐ **At home** ☐ **At work** ☐ **During recreation** ☐ **In school** ☐ **Accident/off road**
☐ **Vehicle collision** ☐ **Illness**

REFERRING DOCTOR: _____

MARITAL STATUS: Married Divorced Single Minor Widowed Legally Separated

SPOUSE'S NAME: _____ **OCCUPATION:** _____

EMPLOYER: _____ **PHONE #:** _____

EMERGENCY CONTACT NAME: _____ **PHONE #:** _____

I authorize the release of any medical or other information necessary to process claims on my behalf.
I agree to be fully responsible for all lawful debts incurred by myself for services received from ***California Hand Rehabilitation, Inc*** *whether covered by insurance or not*

PATIENT SIGNATURE: _____ **DATE:** _____

3273 Claremont Way, Suite 204, Napa, CA 94558 • (707) 259.1152 • fax: (707) 259.1361 • www.calhandrehab.com

CALIFORNIA HAND REHABILITATION
FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment/financial policy.

PRIVATE HEALTH INSURANCE

For all private insurances with HIGH DEDUCTIBLES not met for the year ($500+), we require a payment of $150.00 on the first visit. Follow-up visits will be $125.00 per session that will count towards your TOTAL UNPAID DEDUCTIBLE AMOUNT. Upon receipt of payment for services from your insurance company, adjustments will be made to reflect payments you have made and your deductible level.

Please make sure we are given a copy of your most recent insurance card. Many companies have/are changing identification numbers. If you are unable to provide your insurance card, you will be considered private pay.

Please let us know ASAP if your insurance coverage has changed so we can send the bill to the correct company.

KNOW YOUR COVERAGE! We will bill your insurance after each visit for you. However, **it is your responsibility to know the amount of copay, the amount of your deductible, and any limitations or exceptions set in your coverage**. If you have any questions about your plan, the best source for answers is the 800 number on your card. **If any claim we send to your insurance company is denied, you are responsible for payment.**

ALL COPAYMENTS, DEDUCTIBLES, NO SHOW AND CANCELLATION FEES ARE DUE AT TIME OF SERVICE.

**** We do not accept liens on lawsuits and personal injury cases.**

MEDICARE

We will bill Medicare and your secondary insurance for you. **Medicare** pays **80%** and your secondary **20%.** In the event that you do not have a secondary insurance, **you are responsible for the deductible if still unmet for the year.**

SUPPLIES

If additional supplies are needed, your therapist will discuss this with you before they are issued. Complete payment for all supplies is due on the date these supplies are given to you. Non-emergency supplies will not be issued unless these charges are paid in full.

WORKER'S COMPENSATION

You will be immediately responsible for therapy costs if your Worker's Compensation carrier denies your claim for any reason (i.e. litigation, failure to file claim with employer). Your case manager/adjustor will be notified of any missed appointments. Your compensation will be jeopardized if you miss appointments.

A 24 hour notice is required for cancellation of appointments. If you fail to show up for your appointment, you will be charged a $50.00 no show or late cancel fee that is payable on your next scheduled appointment. Your insurance does not cover this fee.

Please sign below to affirm that you have read, understand, and agree to the financial policy and that you consent to therapeutic services rendered which include modalities or procedures prescribed by your physician. Your signature also confirms that you received a copy of the Privacy Policies of California Hand Rehabilitation, Inc.

Signature: _____ Date: _____

California Hand & Rehabilitation
3273 Claremont Way, Suite 204, Napa, CA 94558

PATIENT MEDICAL HISTORY AND INTAKE SURVEY

Please complete the following as best as you can:

SUBJECTIVE HISTORY:

1. What is your date of injury/start of symptoms? _____
2. How did you injure yourself? _____
3. Have you had any of the following? ___Xrays, date:_____ ___CT scan, date: _____
___ MRI, date:_____ ___EMG/Nerve test, date: _____ ___Injection: :_____
4. Have you had any prior occurrences of this condition? ___YES ___NO If YES, explain_____
5. Have you had prior treatments/surgeries for this injury/condition? ___YES ___NO If YES explain_____

CURRENT COMPLAINT:

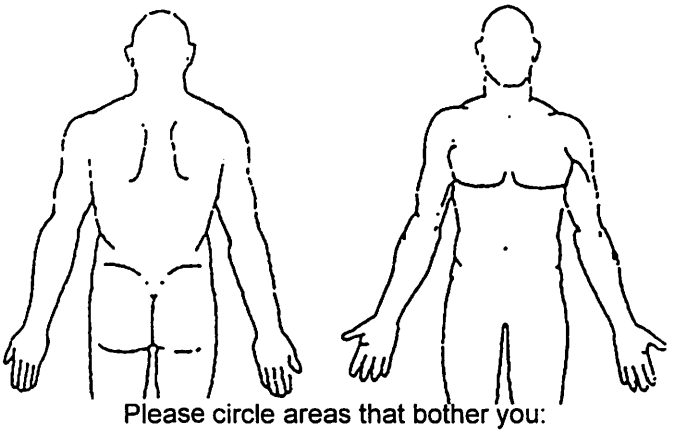
6. What is your chief complaint? _____
7. How often are your symptoms present? ___ Constantly (76-100% of the day) ___ Frequently (51-75% of the day)
___Occasionally (26-50% of the day) ___ Intermittently (0-25% of the day)
8. What makes your symptoms BETTER? _____
9. What makes your symptoms WORSE? _____

PAIN SCALE:

10. If you have PAIN, please circle what your pain level is. (0 =No Pain, 10 =Extreme pain, need to be in the ER)

PAIN level at REST:
0 1 2 3 4 5 6 7 8 9 10

PAIN level WITH ACTIVITIES:
0 1 2 3 4 5 6 7 8 9 10



Please circle areas that bother you:

11. Describe the nature of your symptoms **at REST**: __Sharp __Dull ache __Shooting __Burning __Sore
__Other:_____
12. Describe the nature of your symptoms **WITH ACTIVITIES**: __Sharp __Dull ache __Shooting __Burning __Sore
__Other:_____

MEDICAL HISTORY

13. Dominant Hand: ____RIGHT ____LEFT
14. **Complete your medical history below by checking the appropriate box/es:**

- ◻ Anemia
- ◻ Asthma
- ◻ Cancer (location)_____
- ◻ Depression
- ◻ Diabetes I/II
- ◻ Fibromyalgia
- ◻ Headaches
- ◻ Heart Disease
- ◻ Heat/Cold intolerance
- ◻ High Blood Pressure
- ◻ Kidney problems
- ◻ Liver Problems
- ◻ Night Pain _____
- ◻ Osteoarthritis _____
- ◻ Osteoporosis
- ◻ Pacemaker
- ◻ Dizziness/Fainting
- ◻ Pregnancy (current)
- ◻ Recent fractures _____
- ◻ Rheumatoid Arthritis
- ◻ Seizures/Epilepsy
- ◻ Skin Abnormalities
- ◻ Stroke/TIA _____
- ◻ Surgeries_____
- ◻ Hearing issues/hearing aid
- ◻ Wear glasses/contacts
- ◻ Anxiety
- ◻ Memory Issues
- ◻ Numbness _____
- ◻ Tingling _____

15. **Do you have ALLERGIES? __NO ___YES** _____
16. Do you SMOKE? ___YES How often?_____ ___NO
17. Do you DRINK? ___YES How much?_____ ___NO
18. Who have you seen for your condition before today? ___No one ___Medical Doctor ___OT/PT (where/how may visits?)_____ ___Chiropractor ___Massage therapist ___Acupuncturist

MEDICATIONS

19. **Please list ALL of your current MEDICATIONS AND SUPPLEMENTS that you are taking**

NAME: DOSAGE: FREQUENCY:

_____
_____
_____
_____
_____
_____

MEDICAL PRECAUTIONS/CONTRAINDICATIONS

20. Do you have any PRECAUTIONS/CONTRAINDICATIONS/LIMITATIONS that we need to be aware of?
___YES, explain_____ ___NO
21. Have you fallen in the last 12 months with injury? ___YES, how many times_____ ____NO

OCCUPATION/WORK STATUS

22. What is your OCCUPATION? _____ How Long have you been working there?_____
23. Are you working now? ____YES Status: ◻ Full duty ◻ Modified ◻ Light duty ____NO
24. Please describe your MAIN JOB DUTIES: _____
_____

SOCIAL HISTORY

25. Do you live: ◻ Alone ◻ With spouse ◻ With Family ◻ Assisted living ◻ Other_____
26. What are your INTERESTS/HOBBIES affected by your symptoms? _____
_____
27. Are you a primary CAREGIVER for any family member? ◻ YES ◻ NO
28. Are you able to take yourself to your therapy appointments? ◻ YES ◻ NO _____
29. Any situation that may limit/affect your ability to participate in therapy? _____
_____

LEVEL OF FUNCTION

29. How were you functioning on a daily basis before your injury/illness?
◻ INDEPENDENT ◻ NEEDS SOME ASSISTANCE ◻ DEPENDENT ON OTHERS
30. Do you need to use any of the following? ◻ CANE ◻ WALKER ◻ WHEELCHAIR ◻ SPLINTS/ORTHOTICS

OCCUPATIONAL/HAND THERAPY GOALS

31. What are your goals for participating in therapy? ◻ Return to Work ◻ Be pain-free ◻ Regain as much motion as possible ◻ Be able to do daily tasks without pain/difficulty ◻ Return to sport/hobbies _____
◻ Other:_____

We appreciate your thoroughness in answering the questions. They help us provide you with the best care possible. Thank you!

DISABILITIES OF THE ARM, SHOULDER AND HAND

NAME:

DATE:

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\frac{\text{(sum of n responses)}}{n} - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

DISABILITIES OF THE ARM, SHOULDER AND HAND

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including home-making if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week. Did you have any difficulty:

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

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Patient Insurance Worksheet

We accept most insurances that have in and out-of-network benefits. If you do not have insurance benefits for occupational therapy, please call us at 707-259-1152 to discuss our discount programs. We also have payment plans for patients with high deductibles.

For accurate information, call the member services toll free number on your card. Make sure you speak to a person, and not the automated system. Please call us at 707-259-1152 after you obtain your benefits information and bring this worksheet to your first/next appointment.

Name of person you are speaking with: _____ Time of day: _____
Tracking ID for the call or representative ID: _____

1. How much is my deductible for occupational therapy? _____
2. How much of my deductible has been met? _____
3. Do I have an out of pocket maximum? Yes / No
    a. If yes, amount: _____
        i. Amount met/ satisfied: _____
4. What is my co-insurance percentage(20%, 30%, 40%), or $$ co-pay: _____
5. Does my policy require pre-authorization for occupational therapy services? Yes / No
    a. If yes, what is the number for pre-authorization department: _____
6. How many occupational therapy visits do I have? _____
7. Is there a maximum $$ cap that my plan pays for occupational therapy? Yes/ No
    a. If yes, what is the cap? _____
        i. Has anything been met toward that cap? Yes/ No
            1. If yes, amount: _____
8. What is the billing address for your insurance?

I understand that I am responsible for obtaining accurate information about my insurance benefits so that California Hand Rehabilitation, Inc., can bill them correctly on my behalf. If the above information is inaccurate, I will be responsible for paying the balance for my visits to California Hand Rehabilitation, Inc. _____ *(initial)*
If you need help or have any questions, please do not hesitate to call us at 707-259-1152.

We look forward to helping you get the results you desire.

NOTICE OF PRIVACY PRACTICES

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

USES AND DISCLOSURES

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold rented, transferred, exchanged, and/or used for non-healthcare purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

CERTAIN CIRCUMSTANCES

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

PATIENT RIGHTS

- You have the right to request in writing to inspect and/or receive copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

**Conditions and limitations may apply; obtain additional information from the office.*

CHANGES TO THIS NOTICE: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.