COMMONWEALTH HAND & PHYSICAL THERAPY

PATIENT INFORMATION			
Patient's Full Name (Last, First, MI)			
Address	**CITY**	**STATE**	**ZIP**
DOB:	**SSN:**	**Marital Status:**	
Mobile Phone:	**LandLine Phone:**		
Employer:	**Work Phone:**		
Email:	**How did you hear about us?**		
Emergency Contact Name:	**Relation:**	**Phone:**	
Type of Injury:	WORKERS COMPENSATION	AUTO	OTHER:
Have you had HOME HEALTH CARE services this year?	**If yes, WHEN/WHERE?**		

PRIMARY INSURANCE INFORMATION		
Primary Insurance:		
Subscriber's Name:	**Subscriber's DOB:**	**Relation:**

SECONDARY INSURANCE INFORMATION		
Secondary Insurance:		
Subscriber's Name:	**Subscriber's DOB:**	**Relation:**

GUARANTOR INFORMATION FOR MINORS	
Guarantor Name:	**DOB:**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ (printed name of patient or personal representative) acknowledge that I have received a copy of the Notice of Privacy Practices of Commonwealth Hand Therapy for (check one) _____ me _____ specify name of individual [please print clearly] and agree to the liability limitations explained therein.

_____ _____
Signature of Patient of Personal Representative Date

_____ _____
Print Name Relationship to patient (not self)

For Use By Commonwealth Hand Therapy, LLC. Only

A good faith attempt to obtain a written acknowledgement of receipt of the Notice of Privacy was made, but was not successful for the following reason(s):

____ Patient/personal representative refused to sign
____ Communication barriers prohibited the acknowledgement
____ Emergency situation
____ Other (please specify):_____

_____ _____ _____ _____
Printed Name Title Signature Date

AUTHORIZATION TO SHARE MEDICAL INFORMATION

I, _____ (printed name of patient or personal representative) authorize Commonwealth Hand Therapy, LLC to share information regarding my medical care with the individual(s) and to the degree that I have specified below. This release covers information concerning medical conditions and may include my medical history. I understand that this authorization may be revoked by me at any time (in writing). Authorization will automatically expire in the event that I am no longer a patient of Commonwealth Hand Therapy, LLC. Commonwealth Hand Therapy, LLC is not legally responsible for any disclosure that may arise from the requested information.

I authorize my spouse or family member (name and relationship): _____ to:
___ Discuss medical condition/treatment
___ Receive appointment reminders / attendance compliance
____ Discuss billing / collections on my behalf

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_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name Relationship to patient (not self)

CONSENT TO TREAT

The patient authorizes the Physical, Occupational, and/or Speech Therapist to examine and treat the condition as he/she deems appropriate through the use of physical/occupational, and/or speech therapy measures, and the patient gives authorization for these procedures to be performed.
The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Physical, Occupational, and/or Speech Therapist. The patient will not hold the Physical, Occupational, and/or Speech Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.
The patient has the right to know who is responsible for authorizing any and all treatment procedures.
The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.
The patient shall be advised if Commonwealth Hand Therapy, LLC. proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.
After reading the above (or having it read to me), I _____ hereby consent to receive physical, occupational, and/or speech therapy at Commonwealth Hand Therapy, LLC. commencing on _____ and terminating when determined by myself, my physician or my Physical, Occupational, and/or Speech Therapist.
I have read (or have had read to me) the above information and understand the content.

_____ _____
Patient (or Guardian) Signature Date

_____ _____
Witness Signature Date

COMMONWEALTH HAND THERAPY, LLC

PATIENT AUTHORIZATION FOR E-COMMUNICATIONS

Patient Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____/_____, _____ _____ _____
Street Apt. # City State Zip Code

Telephone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Work Cell

This Authorization is for the use of electronic communications ("e-Communications") via cellular phone (call, voice mail message, text message) and/or email between the above-named Patient and Commonwealth Hand Therapy and its authorized agents (collectively referred to as "CHT").

You are not required to sign this Authorization. However, without your signed Authorization, CHT is under no obligation to engage in e-Communications with you. In such event, communication with you will be limited to regular mail, land-line or work telephone and in-person. If you elect to have e-Communication with CHT by signing this Authorization, you may request to change your preferred method(s) of e-Communication at any time by calling CHT at 859-447-8600 during our regular business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m., and by signing an updated e-Communication Authorization.

Method(s) of E-Communication Authorized

I, _____ ("Patient") hereby authorize e-Communications between myself and Commonwealth Hand Therapy, LLC and/or its authorized agents via the electronic method(s) below and by providing the applicable "Required Information."

e-Communication Method	Required Information
Cellular Phone (phone calls, voice mail messages, text messages)	(_____) _____-_____ Cellular Phone #
Email	_____ Email Address

E-Communication Terms and Conditions

Patient agrees to the following terms and conditions for e-Communication pursuant to this Authorization:

- CHT may e-Communicate with Patient by the method(s) Patient has selected above to remind Patient of scheduled appointments, to schedule or reschedule an appointment, to provide Patient with information related to treatment, and regarding Patient's billing account.
- If e-Communicating with CHT by email, Patient will always put an appropriate subject line in any email message sent to CHT to facilitate CHT's timely response.
- Patient will limit the length of email messages sent to CHT. If the email message contains complex issues, Patient may be asked to call CHT to discuss the subject matter of the email by telephone or in-person.
- All e-Communications between Patient and CHT will become a part of Patient's CHT confidential electronic patient record.
- CHT is not responsible for the failure of any internet or cellular phone connection or service that interrupts e-Communications between CHT and Patient, or for any third party unauthorized access, use or disclosure of e-Communications authorized herein or other security breach beyond CHT's control.
- CHT reserves the right, in its discretion, not to respond to any e-Communication from Patient containing inappropriate language or other content that CHT deems inappropriate, and to suspend or terminate all further e-Communication with Patient in such event.
- **EMERGENCIES. PATIENT UNDERSTANDS THAT PATIENT SHOULD NEVER USE E-COMMUNICATION TO COMMUNICATE TO CHT THAT PATIENT IS HAVING A MEDICAL OR OTHER EMERGENCY. INSTEAD, PATIENT SHOULD CALL 911 OR GO TO A HOSPITAL EMERGENCY ROOM OR URGENT CARE FACILITY.**

- Consent to Wireless Telephone calls: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communication regarding billing and payment for items and services, unless I notify the medical practice to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the medical practice, affiliates, contractors, services, clinical providers, attorneys or its agents including collection agencies.
- Consent to email usage: If at any time I provide my email address at which I may be contacted, unless I notify the medical provider to the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at that email address from the medical provider, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.
- **UNSECURE COMMUNICATIONS WAIVER.** Patient understands and agrees that e-Communication by email and cellular phone is unsecure, and that while CHT will make all reasonable efforts to keep e-Communications with Patient private, confidential and secure, CHT cannot and does not guarantee the privacy, security or confidentiality of any such e-Communication. With this understanding, by signing below, **PATIENT EXPRESSLY FOREVER WAIVES ANY RIGHT TO ASSERT ANY CLAIM OF ANY NATURE AGAINST CHT OR ANY OF ITS OFFICERS, DIRECTORS, EMPLOYEES OR AGENTS ARISING FROM THE UNAUTHORIZED ACCESS BY OR IMPROPER USE OR DISCLOSURE BY AN UNAUTHORIZED THIRD PARTY OF ANY INFORMATION IN SUCH E-COMMUNICATION, INCLUDING PATIENT'S INDIVIDUALLY IDENTIFIABLE HEALTH OR OTHER CONFIDENTIAL INFORMATION IN SUCH E-COMMUNICATION**.

By my signature below, I acknowledge that I have read the foregoing Authorization, and I understand and consent to e-Communication with CHT by the methods I have selected above, and to the e-Communication Terms and Conditions stated herein.

PATIENT / PATIENT AUTHORIZED REPRESENTATIVE:

Signature: _____ **Date**: _____

Print Name: _____

Representative Relationship to Patient (if applicable): _____

WITNESS

Signature: _____ **Date**: _____

Print Name: _____

Patient Name:			**Date of Injury (mm/dd/yyyy):**	
Referring Physician's Name:			**Date of Surgery (mm/dd/yyyy):**	
Cause of Injury:				
Have you had PRIOR PHYSICAL OR OCCUPATIONAL THERAPY this calendar year?			**When/Where?**	
Rate your general health:	**EXCELLENT**	**GOOD**	**FAIR**	**POOR**
HEIGHT:		**WEIGHT (LBS):**		
ARE YOU CURRENTLY PREGNANT?	**DO YOU CURRENTLY HAVE A PACEMAKER?**		**DO YOU HAVE A LATEX ALLERGY?**	
CURRENT MEDICATIONS:				

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS.

____ NUMBNESS/PINS & NEEDLES	____ HEADACHES	____ NIGHT PAIN
____ SUSTAINED MORNING STIFFNESS	____ LIGHT-HEADEDNESS	____ NIGHT SWEATS
____ CONSTIPATION	____ EASY BRUISING	_____ CHANGES IN VISION

PLEASE CHECK ANY CONDITION YOU HAVE BEEN DIAGNOSED WITH (CURRENT OR PAST).

____ ARTHRITIS (RHEUMATOID, OSTEOARTHRITIS)	____ OSTEOPOROSIS	____ ASTHMA
____ RESPIRATORY SYMPTOMS (COPD, ARDS, EMPHYSEMA)	____ ANGINA	____ CONGESTIVE HEART FAILURE
____ HEART ATTACKS	____ NEUROLOGICAL DISEASES (MULTIPLE SCLEROSIS, PARKINSON'S DISEASE)	____ STROKE OR TRANSIENT ISCHEMIC ATTACK
____ PERIPHERAL VASCULAR DISEASE	____ DIABETES (TYPE 1 OR 2)	____ UPPER GASTROINTESTINAL DISEASE (ULCERS, HERNIA, REFLUX)
____ DEPRESSION	____ ANXIETY	____ VISUAL IMPAIRMENTS (CATARACTS, GLAUCOMA, MACULAR DEGENERATION)
____ HEARING IMPAIRMENT	____ CANCER: _____	____ KIDNEY PROBLEMS
____ THYROID PROBLEMS	____ SEIZURES	_____ HEPATITIS OR HIV
____ DEGENERATIVE DISC DISEASE		

RATE YOUR PAIN AT REST (0 = no pain, 10 = worst pain you can imagine):		
RATE YOUR PAIN WITH ACTIVITY (0 = no pain, 10 = worst pain you can imagine):		
WHAT IS THE FREQUENCY OF YOUR PAIN? (circle):	**CONSTANT**	**INTERMITTENT**
DOES YOUR PAIN WAKE YOU AT NIGHT?	**HOW OFTEN?**	

Survey of Upper Extremity Disability (DASH) Date:_____ Date of Birth:_____

Name:_____ Therapist:_____

The Disability of the arm, shoulder and hand (DASH) is a questionnaire to ask you about your symptoms as well as your ability to perform certain activities. Please answer every question, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your best estimate on which response would be most accurate. It does not matter which hand you use to perform the activity; please answer based on your ability regardless of how you perform the task. Please rate your ability to do the following activities by circling the number:

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
Open a tight jar	1	2	3	4	5
Do heavy household chores (e.g., wash walls, floors)	1	2	3	4	5
Carry a shopping bag or briefcase	1	2	3	4	5
Wash your back	1	2	3	4	5
Use a knife to cut food	1	2	3	4	5
Recreational activities which you take some force or impact through your arm, shoulder, or hand (golf, hammering, tennis, etc)	1	2	3	4	5
	Not at All	Slightly	Moderately	Quite a Bit	Extremely
During the past week, to what extent has your arm, shoulder, or hand problem interfered with your normal social activities with family, friends, neighbors, or groups?	1	2	3	4	5
	Not Limited at All	Slightly Limited	Moderately Limited	Very Limited	Unable
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?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week	None	Mild	Moderate	Severe	Extreme
Arm, shoulder, or hand pain	1	2	3	4	5
Tingling (pins & needles) in your arm, shoulder, or hand.	1	2	3	4	5
	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	So Much I can't Sleep
During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	1	2	3	4	5
For office use only *Percent Disability Score ( ) Sum all columns for raw score ( )*					

If this is your first visit, ignore the question below.

Overall, since you started your treatment, has there been any change in your symptoms in your arm, shoulder, or hand during your daily activities? Please indicate if there has been any change by choosing one of the following options.

Worse	Same (0)	Better
___Almost the same, hardly any worse at all (-1)		___Almost the same, hardly any better at all (1)
___A little worse (-2)		___A little better (2)
___Somewhat worse (-3)		___Somewhat better (3)
___Moderately worse (-4)		___Moderately better (4)
___A good deal worse (-5)		___A good deal better (5)
___A great deal worse (-6)		___A great deal better (6)
___A very great deal worse (-7)		___A very great deal better (7)

Please rate your pain level with activity. 0 1 2 3 4 5 6 7 8 9 10

NO PAIN VERY SEVERE PAIN

If this is your first visit, ignore the question:* How satisfied are you with the level of care and services provided? Very, Satisfied, Unsatisfied, Very-Unsatisfied

Please rate your progess with functional activities from start of therapy to this point in time. Excellent Good Fair Poor

At this point in your treatment, have your therapy goals been met? Completely Met Mostly Met Partially Met Not Met

Commonwealth Hand Therapy
330 Waller Avenue, Suite 275
Lexington, KY 40504

EQUIPMENT WARRANTY INFORMATION FORM

All Durable Medical Equipment (DME) sold by our company carries a 1-year manufacturer's warranty. Commonwealth Hand Therapy will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. Commonwealth Hand Therapy will repair or replace, free of charge, equipment that is under warranty, including Medicare-covered equipment.

_____ _____

Beneficiary's Signature Date