PATIENT INFORMATION FORM

_____ _____ _____ _____/_____/_____
Last Name First Name M.I Date of Birth

_____ _____-____-_____
Home Address City State Zip SSN

Home Phone: (_____)_____-_____ Mobile Phone: (_____)_____-_____

Employer: _____ Work Phone: (_____)_____-_____

Email: _____ Emergency: (_____)_____-_____

Emergency Contact Name: _____ Relationship: _____

Martial Status: ☐ SINGLE ☐ MARRIED

PLEASE SELECT YOUR INSURANCE: ☐ COMMERCIAL ☐ WORKERS COMP ☐ AUTO
LET RECEPTIONISTS KNOW IF WORKERS COMP OR AUTO AND PROVIDE CLAIM INFORMATION

Primary Insurance Name: _____-
Patient Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ PARENT

Subscriber Name *(IF NOT SELF):* _____ DOB: _____/_____/_____

Secondary Insurance Name: _____
Patient Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ PARENT

Subscriber Name *(IF NOT SELF):* _____ DOB: _____/_____/_____

Reason for Coming Today: _____

Have you had surgery? ☐ YES ☐ NO IF YES, Date of Surgery: _____/_____/_____

How did you hear about us? _____

HAVE YOU HAD HOME HEALTH CARE SERVICES THIS YEAR? ☐ YES ☐ NO

IF YES, when? _____ What agency provided HH Care? _____

IF UNDER 18:

Parent/Guardian Name: _____

Custody Status: ☐ Mother ☐ Father ☐ Joint ☐ Other: _____

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

In the rare instance of an emergency, who should we contact?

Name:_____ Relationship: _____ Phone:_____

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:

/s/_____ **Date**:_____

Print Name:_____

Representative Relationship to Patient (if applicable): _____

WITNESS

/s/_____ **Date**:_____

Print Name:_____

Commonwealth Hand Therapy Medical History Form

Name: Date of Birth: _____/_____/_____

Date of Next MD APPT: _____/_____/_____											
Referring Physician's name:											
Primary Care Physician name:											
Cause of Injury:											
Date of Injury:_____/_____/_____											
Did you sustain an injury because of a **fall**? YES NO											
Have you recently been hospitalized or had Surgery? YES NO **If Yes**, List which Area was Operated: _____ Date of Surgery: _____/_____/_____											
Describe your General Health: Excellent Good Fair Poor											
Height:	Weight:										
Have you had Prior Physical/Occupational Therapy this Calendar Year? YES NO **If Yes**, where (circle all that apply): Hospital Outpatient Center Home Health											
List Current Medications:											
	No Pain										Worst Imaginable
Please rate your pain at rest	0	1	2	3	4	5	6	7	8	9	10
Please rate your pain with activity	0	1	2	3	4	5	6	7	8	9	10
What is the frequency of your pain?			Constant						Intermittent		
Does your pain wake you at night How Often?	No		Yes								

Commonwealth Hand Therapy Medical History Form

The following questions relate to your current medical history (Please Circle)

Have you recently experienced abnormal sensations (numbness, pins & needles)?	YES	NO
Have you recently experienced headaches?	YES	NO
Have you recently experienced night pain?	YES	NO
Have you recently experienced sustained morning stiffness?	YES	NO
Have you recently experienced light-headedness?	YES	NO
Have you recently experienced trauma (a motor vehicle accident, a fall)?	YES	NO
Have you recently experienced night sweats?	YES	NO
Have you recently experienced constipation?	YES	NO
Have you recently experienced easy bruising?	YES	NO
Have you recently experienced changes in vision?	YES	NO
Are you currently pregnant?	YES	NO
Are you currently aware of a latex allergy?	YES	NO
Do you currently have a pacemaker?	YES	NO

Have you ever been diagnosed with the following? (Please Circle)

Arthritis (rheumatoid and Osteoarthritis	YES	NO
Osteoporosis	YES	NO
Asthma	YES	NO
Respiratory symptoms (COPD, ARDS, Emphysema)	YES	NO
Angina (Chest Pain)	YES	NO
Congestive Heart Failure (or disease)	YES	NO
Heart Attacks (Myocardial Infarct)	YES	NO
Neurological Diseases (Multiple Sclerosis or Parkinson's Disease)	YES	NO
Stroke or Transient Ischemic Attack (TIA)	YES	NO
Peripheral Vascular Disease (PVD)	YES	NO
Diabetes (Type 1 or 2)	YES	NO
Upper gastrointestinal disease (ulcer, hernia, reflux)	YES	NO
Depression	YES	NO
Anxiety or panic disorder	YES	NO
Visual Impairment (cataracts, glaucoma, macular degeneration)	YES	NO
Hearing Impairment	YES	NO
Cancer, If yes what type:	YES	NO
Kidney Problems	YES	NO
Thyroid Problems	YES	NO
Seizures	YES	NO
Hepatitis or HIV	YES	NO
Degenerative Disc Disease	YES	NO

Over the last 2 weeks, how often have you been bothered by the following problems:

	Not at all	Several Days	More than half the day	Nearly every day
1. Poor appetite or over eating	0	1	2	3

Circle the appropriate number to indicate how you generally feel.

	Almost Never	Sometimes	Often	Almost always
3. Some unimportant thoughts run through my mind and bother me	1	2	3	4
4. I am a hot headed person	1	2	3	4

Circle the appropriate number that best corresponds to how you feel.

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
7. I wouldn't have this much pain if there weren't something potentially dangerous going on in my body	1	2	3	4

Please circle the degree to which you have these thoughts and feelings when you experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
8. I cannot seem to keep it out of my mind	0	1	2	3	4

Circle the number (0-6) to indicate how much physical activities affect your current pain

	Completely Disagree						Completely Agree
10. I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
11. My work is too heavy for me	0	1	2	3	4	5	6

Please rate the truth of each statement as it applies to you

	Never True						Always True
14. It's OK to experience pain	0	1	2	3	4	5	6
15. I lead a full life even though I have chronic pain	0	1	2	3	4	5	6

Rate your degree of certainty in performing various tasks during rehabilitation based on the following statement.

	I cannot do it										I am certain I can do it
17 I can complete my therapy no matter how I feel emotionally.	0	1	2	3	4	5	6	7	8	9	10

Commonwealth Hand Therapy Medical History Form

The following questions asks you about your symptoms as well as your ability to perform certain activities. *Please make your best estimate that would be most accurate even if you have not tried!*

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
Open a tight jar	1	2	3	4	5
Do heavy household chores (wash wall, 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 in 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 chores Text	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

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 arms, 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

Signature of Patient		Reviewed by Therapist		Date	

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