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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | | | | Date of birth: | | | | | | | | Age: | |
| Address: |  | | |  | | | City: | | | | | State: | | | Zip: | |
| Email: |  | | | o Male ← please indicate what is on record with insurance  o Female Preferred pronouns (optional): | | | | | | | | | | | | |
| Primary Phone: ( ) | | | | Text ok? Y / N | | | Alternate Phone: ( ) | | | | | | | | OK to receive  texts ? Y / N | |
| I would like appointment reminders by: o Email o Phone Call o Text Social Security Number: | | | | | | | | | | | | | | |  | |
| Emergency  Contact: |  | | | Relationship: | | | Phone: ( ) | | | | | | | | | |
| Primary Care Doctor/Clinic: |  | | |  | | | Phone: ( ) | | | | | | |  | | |
| Date of symptom onset/injury: | | |  | Date of surgery: | | |  | | | | o Injured on the job  o Injured in an auto accident o neither | | | | | |
| Have you received OT, PT or speech therapy *for any reason* this year? o No o Yes, for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you received a splint, brace or cast *for any reason* this year? o No o Yes, for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare Part B patients: Have you received a splint, brace or cast for this specific injury & body part in *the past 5 years*? o No o Yes  If you marked yes, Medicare *may* not cover your splint and we can extend our discounted cash price to you. (Office: offer ABN) | | | | | | | | | | | | | | | | |
| Please provide ALL insurance information.  We bill in this order: | | Work Comp  (if applicable) | | | > | Auto (if applicable) | | > | Private Insurance (primary) | | | > | Private (secondary) (if applicable) | | > | You |
| **PRIVATE INSURANCE** **Primary**: | | | |  | | | | | |  | | | | | | |
| Subscriber Name | | | |  | | | | | | Subscriber DOB: | | | | | | |
| \*\***IMPORTANT**! If no private insurance information is provided and no other insurance pays,  you will be responsible for therapy charges of $120 per visit, plus applicable splinting charges.\*\* | | | | | | | | | | | | | | | | |
| **PRIVATE INSURANCE Secondary**: | | | |  | | | | | |  | | | | | | |
| Subscriber name | | | |  | | | | | | Subscriber DOB | | | | | | |
| **WORK COMP** **Insurance Name**: | | | |  | | | | | | Claim # | | | | | | |
| Employer: | | | | Adjuster Name: | | | | | |  | | | | | | |
| Job Title | | | |  | | | | | | Adjuster Phone: ( ) | | | | | | |
| **If Auto Accident, MVA**  **Insurance Company:** | | | | | | Claim/Policy # | | | | | | | Accident occurred in  o OR o WA o Other: | | | |
| **Attention MVA patients!** Please be certain to also **provide your Private Health insurance** to protect you from avoidable expenses | | | | | | | | | | | | | | | | |
| Do you have an attorney representing you for your current condition? o Yes o No | | | | | | | | | | | | | | | | |
| Attorney: | | | |  | | | | | | Phone: ( ) | | | | | | |
| Other than your insurance, doctor, or attorney, list person(s) allowed to receive your medical and billing information: | | | | | | | | | | | | | | | | |
| Name: | | | | Relationship: | | | | | | Phone: ( ) | | | | | | |
| Name: | | | | Relationship: | | | | | | Phone: ( ) | | | | | | |

I authorize my insurance company to make payment directly to Armworks Hand Therapy, LLC (AHT). I give AHT permission to send all necessary information about my claim and injury to my insurance company. If the patient is a minor, I, as Parent/Guardian, authorize AHT to treat my minor child. I have read and agree to the terms stated on the Notice of Privacy Practices and Notice and Agreement forms. A paper copy was offered to me if requested in the office during my visit. I hereby consent to the provision of treatment by AHT. I authorize AHT to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition.

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| Signature: | Date: |
| Name of signer if patient is a minor: | Relationship: |