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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: |