1201 Nott St.
Suite 105A
Schenectady,NY 12308

Phone: 518-377-9227

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Capital District Hand

Physical & Occupational Therapy Service, PLLC

PATIENT REGISTRATION

NAME :_____ SS#_____

ADDRESS:_____CITY:_____STATE:_____ZIP_____

AGE:_____DOB_____SGL MAR WID SEP DIV PHONE: (H)_____ (C)_____EMAIL_____

EMPLOYER:_____ PHONE:_____

PRIMARY PHYSICIAN:_____PHONE:_____

REFERRING PHYSICIAN:_____PHONE:_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____PHONE:_____

SPOUSE'S INFORMATION: NAME:_____CELL:_____

IF PATIENT IS A DEPENDENT:

FATHER'S NAME:_____ PHONE**:**(H)_____(C)_____(W)_____

ADDRESS:_____

MOTHER'S NAME:_____PHONE:(H)_____(C)_____(W)_____

ADDRESS:_____

PLEASE READ AND SIGN THE AUTHORIZATION BELOW:

Our office is committed to providing you with the best possible care. While the filing of insurance claims is a courtesy that we extend our patients, all charges are your responsibility from the date services are rendered**. If you fail to keep a scheduled appointment and do not cancel said appointment, we reserve the right to charge $25.00 no-show fee.**

I agree to pay co-payments (if any) as services are rendered and any outstanding balance upon receipt of statement.

I understand that it is my responsibility to be knowledgeable of my insurance benefits for outpatient physical and occupational therapy. It is my responsibility to inform Capital District Hand, PT & OT Svc. , PLLC immediately of any changes to my insurance coverage during my course of therapy. Failure to do so may result in additional financial responsibility owed by me due to insurance denials based upon claims that are not filed in a timely fashion or filed with inaccurate data*. I understand that my insurance company may not cover physical therapy if combined with other services such as chiropractic care or home based physical or occupational therapy. I will be responsible for any services denied for this reason*. If I am involved in a No-Fault, personal injury, or Workers' Compensation case, I will be responsible for any claims that are denied. If I willingly and knowingly exceed the number of visits covered by my insurance company, I will be responsible for payment in full for each visit the insurance company does not authorize. I understand there is a cap of $1,920.00 for Medicare coverage of physical therapy and occupational therapy each. I authorize Capital District Hand, Physical and Occupational Therapy Service, PLLC to release such information as required by my attorney and/or insurance company to secure my insurance benefits. I understand I will be responsible for services not covered by my insurance company and failure to supply necessary referrals or prescriptions to secure payment of my account. A photocopy of this authorization shall be valid as the original. I assign all medical benefits to which I am entitled to CDHPT&OT Svc., PLLC.

SIGNATURE_____ DATE_____

MEDICAL QUESTIONNAIRE

NAME:_____ Date:_____

In order to provide the best care for our patients, we at Capital District Hand, PT &OT Service, PLLC. Request that you complete this form. Yo8ur health history and current medications can provide us with important information that might affect your healing and treatment. This information remains strictly confidential. If you have any questions, please speak to your therapist. Thank you.

Are you currently receiving in- home therapy?_____If yes, please explain_____

Have you ***previously*** had an injury or surgery to the arm or hand other than the one for which you were referred here?

Yes___ Please describe and indicate date(s)_____ No_____

Do you have, or take medication for:			Please list medications:
Diabetes	Yes_____	No_____	_____
Heart disease	Yes_____	No_____	_____
Cancer	Yes_____	No_____	_____
HIV/AIDS	Yes_____	No_____	_____
Rheumatoid arthritis	Yes_____	No_____	_____
Hepatitis	Yes_____	No_____	_____
Osteoarthritis (“wear and tear”)	Yes_____	No_____	_____
Pain medications	Yes_____	No_____	_____
Have you had recent surgery?	Yes_____	No_____	Explain_____

_____

Please list any allergies:_____

_____

Any additional information you think might be helpful:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I received, understand and agree to the Notice of Privacy Practices of Capital District Hand, PT & OT Service, PLLC, which describes the practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice. This information is available at the company's office.

Signature_____ Date_____

Print Name_____

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The practice has made a good faith effort to obtain an acknowledgement of

_____ receipt of our Notice of Privacy Practice. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons: (check all that apply)

Patient unavailable
Patient physically unable
Patient unwilling

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide the patient with Notice of Privacy Practices in the following manner (check all that apply):

___personally ____mail _____phone follow up _____other

_____ _____

Date Signature