



Please provide a valid insurance card and photo ID upon check-in

PATIENT INFORMATION

Patient Name: _____ SS#: _____ - _____ - _____ Birth Date: _____

Address: _____ E-Mail: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____ (Cell/Pager)

Referring Doctor: _____ Primary Care Physician: _____

Patient Employer: _____ Occupation: _____

Medical Conditions: _____

List Any Allergies: _____

Current Medications: _____

Is this visit the result of a work injury? YES NO

- Date of Injury _____
- How Injury Occurred _____
- Attorney (name & phone): _____

Ins. Co _____ Phone# _____ Claim# _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

RESPONSIBLE PARTY (if other than patient)

Name: _____ SS#: _____ - _____ - _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____ (Cell/Pager)

INSURANCE INFORMATION:

Primary Insurance Company:

Secondary Insurance Company:

Policy Holder's Name: _____

Policy Holder's Name: _____

Primary Ins. Co.: _____

Secondary Ins Co: _____

Address: _____

Address: _____

Insurance Co. Phone: _____

Insurance Co. Phone: _____

S.S.#: _____ - _____ - _____ Birth Date: _____

S.S.#: _____ - _____ - _____ Birth Date: _____

Employer _____

Employer _____

Policy#: _____ Copay \$: _____

Policy#: _____ Copay \$: _____

Grp#/Claim#: _____ Deductible \$ _____

Grp#/ Claim# _____ Deductible \$ _____

Please provide complete insurance information upon your initial visit. **All co-pays are due in full at the time of service.** Your insurance company may require that you meet a deductible prior to your insurance benefits becoming effective. Please notify us immediately about changes in your insurance coverage or if your claim has been denied (i.e. worker's compensation cases).

Central Hand Therapy/Southern Arizona Community Occupational Therapy Associates staff will work collaboratively with you to ensure the best functional outcome possible after injury or surgery and we will bill your insurance company for the services you receive. **Although we submit bills to your insurance company for the cost of therapy services, you, the patient are ultimately responsible for payment should your insurance deny the claim and/or require you to meet a deductible.** Signing below indicates that you have read, understand and will comply with the billing procedure.

***Please note we require a parent or guardian remain in the clinic at all times during pediatric treatment.

I authorize Central Hand Therapy/Southern Arizona Community Occupational Therapy Associates to release any information including diagnosis and records of any treatment or examinations rendered to me to my insurance company.

Signature: _____ Date: _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, *Central Hand Therapy, PC/Southern Arizona Community Occupational Therapy Associates (SACOTA)* maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Central Hand Therapy, PC / Southern Arizona community Occupational Therapy Associates are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organizations have already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, these organizations may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Central Hand Therapy, PC / Southern Arizona Community Occupational Therapy Associates reserve the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the code of Federal Regulations. Should Central Hand Therapy, PC/Southern Arizona Community Occupational Therapy Associates change their notice, they will send a copy of any revised notice to the address I have provided whether U.S. mail or, if I agree, via email.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsimile.

I FULLY UNDERSTAND AND ACCEPT/DECLINE THE TERMS OF THIS CONSENT.

Patient's Signature

Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____



CANCELLATION / MISSED APPOINTMENT POLICY

It is critical for continuity of your care that you attend all scheduled appointments. We will make every effort to accommodate your scheduling needs. In return, we ask that you commit to keeping all scheduled appointments and notify us **at least 24 hours in advance** if you need to reschedule or cancel an appointment.

~Thank you

Please read and sign our policy as indicated below:

ALL PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENTS OR WHO CANCEL WITH LESS THAN 24 HOURS ADVANCE NOTICE WILL BE CHARGED A MISSED APPOINTMENT FEE

- Please note: This missed appointment fee is **NOT** covered by your insurance and you are responsible for 100% of the missed appointment fee. To avoid a charge, please give us at least **24 hours** notice if you need to reschedule your appointment.
- If you fail to arrive for your appointment and have not notified us 24 hours in advance, you will be charged a **\$25 missed appointment fee**
- This fee will be charged to your credit card on file in our office or billed directly to you
- Due to the progressive nature of therapy, it is important that you adhere to the therapy schedule outlined by the therapist.
- **Missed appointments or “no shows” will result in the cancellation of future appointments until you contact our office. In the event that three appointments in your therapy schedule are missed, without supporting medical documentation, we will cancel all remaining appointments and notify the referring physician that your child has been administratively discharged.**

Thank you for your assistance in ensuring we are able to accommodate all patients who need our care.

I (please print patient or legal guardian name) _____ have read, understand and agree to the terms of this policy.

Patient Name (please print) _____

Patient or Legal Guardian Signature _____

Date _____