WELCOME TO OUR CLINIC! **FOLEY HAND THERAPY – FHT**

Patient Information

First Name_____ MI ____ Last Name_____ DOB ___ /___ /___

Address_____ Apt#_____ City_____ State____ Zip_____

Cell Phone ( ) _____-_____ Alternate Phone ( ) _____ -_____ ❑Male ❑Female

Employer Name and Address _____ Phone ( ) ____ -_____

Social Security #_____ -_____- _____

Were you referred to us because of an accident? **❑Auto** **❑Work** **❑Other Incident** **❑No**
Injury date and details _____

Have you received any Occupational, Physical or Speech Therapies or Chiropractic Treatment during this current insurance plan year? **❑Yes** **❑No.** If yes, how many visits? _____

Are you **now** or **within** the last 60 days receiving home-health care for any reason **or** any care at an outpatient hospital facility or nursing home facility? **❑Yes** **❑No.** If yes, give name and address of other provider_____

Referring Provider_____ Primary Care Physician_____ Last MD Visit___ /___ /___
Diagnosis: Injury/Body Part(s) _____ Date of Surgery ____ /____ /____
Parent Name_____ Address _____ Phone ( ) ____ - _____
(If patient is a minor) (If different than above)

Medical Insurance Information

Primary Insurance _____ Address _____
Policy #_____ Group #_____ **❑HMO** **❑POS** **❑PPO** **❑I** **❑WC**

Secondary Insurance _____ Address _____
Policy #_____ Group #_____ **❑HMO** **❑POS** **❑PPO** **❑I** **❑WC**
(If your insurance requires pre-authorization to service, it is your responsibility to obtain)

Marital Status: ❑Single ❑Married ❑Widow(er) ❑Divorced ❑Separated

Claim Information (If Applicable)

❑L&I Claim ❑Worker's Comp/Self-Ins Claim
Claim Manager's Name _____ Phone ( ) _____ -_____ - Ext_____

Does your insurance cover Occupational Therapy? **❑Yes** **❑No**
What is your deductible? _____ How much have you met? _____ What is your copay? _____

Copayment I agree to pay $_____ copayment for services accrued in full at time of service.

In case of emergency, contact _____ Phone ( ) _____ -_____

This Benefit Verification form is only a potential explanation of coverage obtained from the patient's insurance company & is not a guarantee of coverage, eligibility or payment. If the information provided by the insurance company is not accurate or the insurance company changes its coverage, the patient will be responsible for payment for services.

Patient Authorization, Release and Signature: I do not hold FHT &/or its affiliates responsible for any incorrect or omitted information, or for any changes in my future coverage. I also agree that I am responsible for the contract between myself & my insurance company.

Patient or Parent/Guardian Signature _____ Date_____

FOLEY HAND THERAPY – FHT
3221 Waialae Ave., Ste. 360, Honolulu, HI 96816 Ph. (808)732-7744 Fax. (808)732-7766

Patient Name:_____

Patient's Rights and Responsibilities

The patient has the right • to considerate and respectful service. • to obtain service without regard to race, creed, national origin, sex, age, disability diagnosis or religious affiliation. • (subject to applicable law) to confidentiality of all information pertaining to his/her service. [Individuals or organizations not involved in the patient's care may not have access to the information without the patient's written consent.] • to make informed decisions about his/her care. • to reasonable continuity of care and service. • to voice grievances without fear of termination of service or other reprisal in the service process.

The patient is responsible • for notifying FHT of any FHT DME (equipment) failure or damage. • for any FHT equipment that is lost or stolen while in their possession for notifying FHT of such loss. • for notifying FHT of any changes to their address or telephone. • for notifying FHT of any changes concerning their physician. • for notifying FHT of discontinuance of use of issued FHT equipment. • for any equipment rental and sale charges which the patient's insurance company does not pay, except where contrary to federal or state law.

HIPAA Privacy Policy *Effective: 04/14/2003, Updated 03/25/13*

I understand that FHT is in HIPAA compliance regarding maintaining the highest degree of confidentiality of my personal and medical records information. A copy of the HIPAA Privacy Policy has been made available to me.

Assignment of Benefits and Payment Guarantee

I authorize insurance payment directly to FHT for services. This is a direct assignment of my rights and benefits under this insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original.

As the ultimate responsible party, I agree to pay FHT for the services provided to me. If any law (such as workers compensation) or insurance contract prohibits payment for these services, I will cooperate and assist FHT in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatment unless agreed to in writing by myself and a FHT representative.

***If I am a Medicare patient**, then I, the above named patient and Medicare beneficiary, with Medicare number _____ and Medigap or supplement insurance policy number _____, request that payment of authorized Medicare and Medigap or supplemental benefits be made either to me or on my behalf to FHT for any services furnished me by FHT. This authorization applies to all occasions of services until it is revoked.*

Effective April 15, 2014

**If you are unable to keep a scheduled appointment,
please call FHT 24 hours prior to your scheduled appointment time. Otherwise, there will be
a $25.00 charge for missed appointments or late cancellations.**

Patient or Parent/Guardian Signature:_____ Date:_____

PATIENT INFORMATION AND BRIEF MEDICAL HISTORY FOLEY HAND THERAPY - FHT

Did you get a **Physician's Referral/Prescription** ❑ **Yes** ❑ **No.** If Yes, give name of referring/prescription physician:

_____ Phone ( ) _____ -_____

Patient's Diagnosis: _____

Permission to Text Appointment Reminders ❑ **Yes** ❑ **No**

❑ I hereby give permission for FHT &/or Affiliates to leave a detailed message on my voicemail/answering machine.

❑ I hereby give permission for FHT &/or Affiliates to send me email messages.

Email Address _____

How did you hear about us? ❑Health Care Provider ❑Friend/Relative ❑Website ❑Other _____

Do you now have -- or have you ever had -- any of the following?

Yes	No	Condition		Yes	No	Condition		Yes	No	Condition
		Diabetes				Open Wounds related to current condition				Thyroid Problems
		Arthritis				Current Infection(s)				CVA / Stroke
		High Blood Pressure				Hypersensitivity to Heat or Cold				Previous Fracture
		Heart Disease				Allergies / Asthma				Osteoporosis
		Heart Attack				Hernia				Depression
		Pacemaker or Surgical Implant				Presently Pregnant				Anxiety
		Vascular Disease				Seizures				Substance Abuse
		Headaches / Migraines				Metal in Body				Previous surgeries
		Kidney Problems				Cancer / Tumor				Other

If you answered "yes" on any of the above, please explain and give approximate date(s):

_____

_____

_____

_____

Do you have any allergies? ❑ **Yes** ❑ **No** If yes, explain:

_____

_____

Are you presently taking any medications? ❑ **Yes** ❑ **No** If yes, please list medications:

_____

_____

_____

_____

List all major injuries, surgeries and/or recent hospitalizations you have had:

_____

_____

_____

Patient or Parent/Guardian Signature _____ Date _____

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PAIN INFORMATION INTAKE

Pain Level

Please mark your pain level on the scale below.

0 1 2 3 4 5 6 7 8 9 10

(none) **(excruciating)**

If none, stop here.

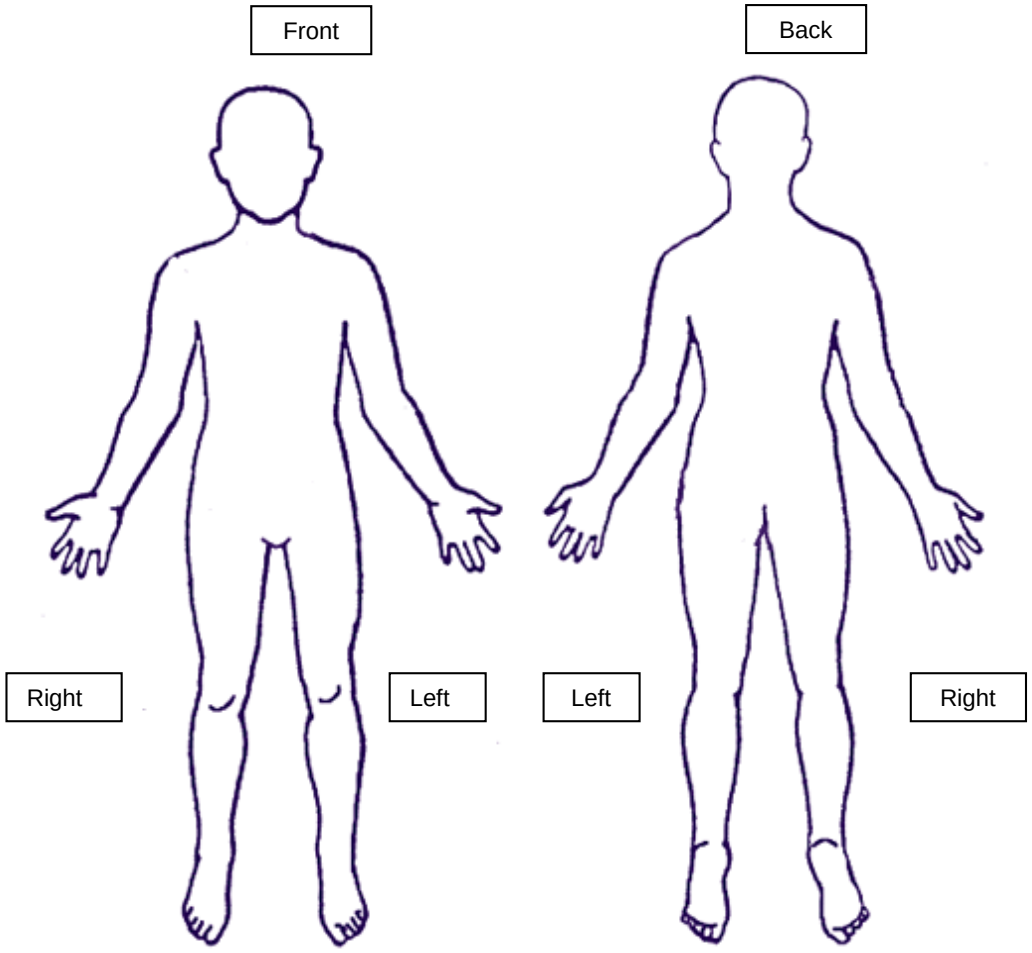
Pain Description

Please mark all that apply in describing your pain.

Aching	Tender	Sharp	Dull	Burning
Throbbing	Numb	Tingling	Pins & Needles	Heavy
Tired	Tight	Shooting	Radiating	Cramping

Pain Location

Please mark where you feel the pain.



Patient or Parent/Guardian Signature:_____ Date:_____

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Patient Authorization for Release of Information

Authorization is required for the Use or Disclosure of Information
Related to Treatment, Payment, Healthcare Operations unless otherwise permitted by Law or Rules

Patient PRINTED Name:_____

Patient Date of Birth:_____/_____/_____ Social Security Number:_____/_____/_____

I understand that my provider will need to communicate with my physician about my healthcare. I also understand that in order for my insurance company to process and pay on claims for my treatment, they will also need information about my healthcare; and by denying the insurance company such information, I will need to pay in full in cash for my treatment at this facility.

FHT may release my information to:

My Doctor:_____My Insurance Company: _____

Other:_____

Other: _____

✓ Yes, you may release this information as long as my file is active unless I herein specify a duration or expiration date.

If No, please specify duration or expiration date: _____

FHT may obtain my information:

I hereby authorize Foley Hand Therapy, LLC to obtain all medical records and/or professional information FROM my physician or other medical professional AS IT RELATES TO MY CURRENT TREATMENT.

I may request restrictions as to how my health information may be used although FHT is not required to agree to those restrictions if in violation of HIPAA compliance.

I may revoke this authorization in writing at any time, although FHT can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that take place before the consent was revoked.

I indicate understanding and consent for use of health information related to our service.

Signature of Patient:_____Date_____

OR

Signature of Parent/Guardian or
Authorized Representative:_____Date_____

FINANCIAL POLICY / BASIC INSURANCE INFORMATION

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We think that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

1. **ALL NEW** patients are expected to present current and active proof of insurance. FHT will bill your insurance company; however, **you are responsible for your deductible, co-pays and any amount that may not be covered by your insurance.**

2. **Deductible and co-pays** are to be paid at time of service. This can be paid by cash or credit card [Discover, MasterCard, and Visa].

3. **NSF CHECKS** will be charged $30.00 plus the amount of the check. This is due upon your next appointment or immediately upon notification.

4. **MISSED/BROKEN APPOINTMENT CHARGE** for any patient who cancels with less than 24-hour notice or who does not present at the appointment time:
   Therapy visit: $25.00
   Orthotic visit: $30.00

The fee is due upon the next visit.

IT IS YOUR RESPONSIBILITY TO MONITOR YOUR BENEFITS AND ANNUAL MAXIMUM. We will be happy to assist you, but it is your responsibility.

PATIENTS WITH HMO PLANS: It is your responsibility to know and understand your HMO plan. Generally, these plans require a patient to pay a co-pay at the time of service.

FOR YOUR CONVENIENCE WE ACCEPT CASH, DISCOVER, MASTERCARD, AND VISA.

We ask that you provide us with a valid credit card number to transfer any unpaid balance that is delinquent over 90 days.

I HAVE READ AND AGREE TO THESE TERMS.

_____ _____
Patient or Parent/Guardian Signature Date

Patient or Parent/Guardian PRINTED Name_____

DISCLAIMER STATEMENT

Foley Hand Therapy (FHT) is solely owned by Dolly Foley. FHT provides services that are in conjunction with and regulated by various professional health care organizations.

Compression Garment Company (CGC) is also solely owned by Dolly Foley. CGC was created to fill the need for high quality and affordable compression garments to be offered to patients of FHT and to be offered to other health care professionals for their patients.

Dolly Foley will not in any way persuade, influence, entice, encourage, coerce, manipulate, force, oblige, necessitate, compel, urge, convince, etc., any patient/customer to purchase any product from CGC.

Dolly Foley expects all patients/customers to be diligent in their efforts in comparing quality, price and service that best serves the patient/customer.

CGC does not file insurance claims nor does it bill insurance.

Patient/Customer Signature: _____ Date: _____