

**WELCOME TO HAND THERAPY SERVICES**

Patient Name: \_\_\_\_\_ A.K.A \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

Male / Female    Married / Single / Widowed    Which hand is your dominant hand? Right / Left

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Job Title: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Race: \_\_\_ American Indian/Alaska Native \_\_\_ Asian \_\_\_ Black/African American \_\_\_ White  
\_\_\_ More than one race \_\_\_ Native Hawaiian \_\_\_ Pacific Islander \_\_\_ Unreported/Refused to report  
Ethnicity: \_\_\_ Hispanic/Latino \_\_\_ Non-Hispanic/Latino \_\_\_ Unreported/Refused to report

---

**PRIMARY** Insurance Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Guarantor's Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Guarantor's Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

---

**SECONDARY** Insurance Name: \_\_\_\_\_

Guarantor's Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Guarantor's Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

---

Referring Doctor's Name: \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT:** \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**PLEASE ANSWER ALL OF THE FOLLOWING:**

Briefly describe your injury: \_\_\_\_\_

Have you had surgery?  Yes  No If yes, when? \_\_\_\_\_

Are you taking medication for:

Pain  Diabetes  Blood Pressure  Cholesterol  
 Heart  Thyroid  Vertigo  Blood Thinner

Other: \_\_\_\_\_

In general, you would rate your overall health as:  Excellent  Good  Fair  Poor

Have you ever experienced heart problems, including heart surgery?  Yes  No

Do you have a pacemaker?  Yes  No

Have you ever tested positive for tuberculosis?  Yes  No

Do you have diabetes?  Yes  No

Do you have a history of seizures?  Yes  No

Do you have a history of dizziness?  Yes  No

Do you have a history of hypertension?  Yes  No

Do you have any joint or muscle problems or injuries?  Yes  No

Do you have neck problems including neck surgery?  Yes  No

What are your hobbies/sports? \_\_\_\_\_

Are you able to perform them at this point?  Yes  No

If employed, are you working at this time?  Not employed

If yes: Light Duty  Modified Duty  Regular Duty

Were you seen by a physical therapist or a chiropractor regarding this injury before your doctor referred you to us?  Yes  No

If yes, how many weeks were you treated? \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Hand Profile

### RATE YOUR PAIN

Rate the average amount of pain in your wrist/hand over the past week by circling the number that best describes your pain on a scale from 0-10. A zero (0) means that you did not have any pain and a ten (10) means that the pain is the worst possible (i.e. worst you have ever experienced or that you could not do the activity because of pain)

#### At Rest

None Worst  
0 1 2 3 4 5 6 7 8 9 10

#### When doing a task with a repeated wrist/hand movement

None Worst  
0 1 2 3 4 5 6 7 8 9 10

#### When lifting a heavy object

None Worst  
0 1 2 3 4 5 6 7 8 9 10

#### When it is at its worst

None Worst  
0 1 2 3 4 5 6 7 8 9 10

#### How often do you have pain

Never Always  
0 1 2 3 4 5 6 7 8 9 10

### SPECIFIC ACTIVITIES

Rate the amount of difficulty you experienced performing each of the items listed below - over the past week, by circling the number that describes your difficulty on a scale of 0-10. A zero (0) means you did not experience any difficulty and a ten (10) means it was so difficult you were unable to do it at all

#### Turn a door knob using my affected hand

No Difficulty Unable To Do  
0 1 2 3 4 5 6 7 8 9 10

#### Cut meat using a knife in my affected hand

No Difficulty Unable To Do  
0 1 2 3 4 5 6 7 8 9 10

#### Fasten buttons on my shirt

No Difficulty Unable To Do  
0 1 2 3 4 5 6 7 8 9 10

#### Use my affected hand to push up from a chair

No Difficulty Unable To Do  
0 1 2 3 4 5 6 7 8 9 10

#### Carry a 10lb object in my affected hand

No Difficulty Unable To Do  
0 1 2 3 4 5 6 7 8 9 10

**Use bathroom tissue with my affected hand**

No Difficulty

Unable To Do

0 1 2 3 4 5 6 7 8 9 10

**USUAL ACTIVITIES**

Rate the amount of difficulty you experienced performing your usual activities in each of the areas listed below, over the past week, by circling the number that best describes your difficulty on a scale of 0-10. By "usual activities", we mean the activities you performed before you started having a problem with your wrist/hand. A zero (0) means that you did not experience any difficulty and a ten (10) means it was so difficult you were unable to do any of your usual activities

**Personal care activities (dressing, washing)**

No Difficulty

Unable To Do

0 1 2 3 4 5 6 7 8 9 10

**Household work (cleaning, maintenance)**

No Difficulty

Unable To Do

0 1 2 3 4 5 6 7 8 9 10

**Work (your job or usual everyday work)**

No Difficulty

Unable To Do

0 1 2 3 4 5 6 7 8 9 10

**Recreational activities**

No Difficulty

Unable To Do

0 1 2 3 4 5 6 7 8 9 10

**Appearance - Optional**

**How important is the appearance of your hand**

Very Much    Somewhat    Not at all

**Rate how dissatisfied you were with the appearance of your wrist/hand during the past week.**

No Dissatisfaction

Complete Dissatisfaction

0 1 2 3 4 5 6 7 8 9 10

## SHEA PHYSICAL THERAPY/HAND THERAPY SERVICES

### Policy for Cancellations and No Shows

These policies have been developed to assist our therapist in scheduling their patients efficiently so that each of you will be given the appropriate time when you arrive for your treatment session. We appreciate you assisting us in the matter of **cancellations** and **no shows** for our operation.

1. We will request a 24 hour notice in the event of a cancellation. It is the patient's responsibility, when you call in, to have an alternative time in mind that will ensure that you get in the full prescribed number of treatments that week whenever possible.
2. Please understand that when you do not show, three people are affected:
  - a) First the patient because you do not get the treatment you need as prescribed by the doctor.
  - b) Second, the therapist who now has a space in their schedule since the time was reserved for you personally.
  - c) Third, another patient could have been scheduled for treatment if there had been proper notice.

Should you have to reschedule, please understand that you may need to see a clinician other than the one who normally treats you as a result of rearranging the appointment period. All of our clinicians are experienced professionals, and they will study your chart, so you will be in good hands. You will return to the original clinician in the next regularly scheduled visit.

Should you need to cancel or change an appointment, please contact our office directly; for Shea Physical Therapy (361) 994-5224 and for Hand Therapy Services (361) 992-1435. Again this policy is to assist our facility to offer you the patient a much more efficient operation. We strive to minimize the amount of wait time that you may have in our lobby by keeping our therapists on a regular schedule.

We look forward to having the opportunity to work with you and to assist you in your current therapy need.

Sincerely,

Daniel R. Shea, P.T  
Shea Physical Therapy

Sheila Heflin, OTR, CHT  
Hand Therapy Services

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## **Consent for Treatment/ Privacy Policy/ Assignment of Benefits**

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. On your initial visit the therapist will evaluate you as it relates to your diagnosis. Following the evaluation, a plan of care will be developed in cooperation with your physician. Risks, side effects, complications and benefits of treatment will be discussed with you. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills are handled.

### **EXPLANATION OF INSURANCE COVERAGE**

Most insurance policies cover physical therapy, but this office does not ensure that yours does. Insurance policies can differ greatly in terms of coverage for physical therapy. Because of the variance of one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and we will bill your insurance company (ies) in a timely manner.

### **I. ASSIGNMENT OF BENEFITS**

**Authorization of payment:** I hereby assign all benefits directly to Shea Physical Therapy. If my insurance carrier sends me payment for services incurred in this office, I shall send or bring the full payment to your office immediately upon receipt. I understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment in full.

\_\_\_\_\_  
Signature Date

### **II. SUMMARY OF BENEFITS**

Deductible: \$\_\_\_\_\_ -has been met/not met \$\_\_\_\_\_ coverage % \_\_\_\_\_ co-pay\$\_\_\_\_\_

- Your insurance carrier(s) covers the following:  
\_\_\_\_\_ Visit(s)/dollar(s) per calendar year. \_\_\_\_\_ Procedure(s) per visit.
- The following services are not covered by your insurance carrier:

- \_\_\_\_\_  
• \_\_\_\_\_ Your insurance will not cover these services and you will be responsible for payment of the services you receive.

#### **Terms of Benefits**

**This is a description of benefits, as given to us by your insurance company. This information is provided to you as a courtesy only. It is the patients responsibility to check with your insurance to verify benefits/coverage. Summary of benefits is not a gurantee of payment and is subject to change. I fully understand that any unpaid portion of services rendered is my responsibility. Quotes are an estimated calculation, according to the description of benefits given by my insurance company. I agree to the terms and conditions presented to me by Shea Physical Therapy.**

**I acknowledge and accept the terms and conditions set forth in Sections I and II of this statement:**

---

Signature

---

Date

**III. CONSENT FOR RELEASE OF INFORMATION**

The undersigned authorizes the release of any personal health information required for treatment, payment or health care operations. This may include physicians, case managers, and insurance carriers or third party payers. Further, the undersigned releases Shea Physical Therapy to provide outside healthcare providers/services such information as is necessary to facilitate proper healthcare. In addition, the patient consents to the release of prior medical records from referring physicians, hospitals, case managers, or other entities, which have records necessary for proper evaluation and treatment of the patient. All other uses and disclosures will be made only with your written authorization. You have the right to revoke authorization for further uses and disclosures at any time.

**IV. CONSENT FOR TREATMENT**

I consent to rehabilitation and incidental medical services at Shea Physical Therapy. I understand the expected benefits, possible risks, side effects, complications and discomforts of my rehabilitation. I know and agree that Shea Physical Therapy is not responsible for lost or damage to personal valuables.

**V. PRIVACY POLICY**

Shea Physical Therapy will administer your records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. I have received a copy of the notice of privacy practices.

**I acknowledge and accept the terms and conditions set forth in Sections III. IV. and V of this statement.**

---

Signature

---

Date

---

Witness' Signature (staff)

---

Date

We hope this answers any questions you might have concerning the financial policies of this office. Once again we welcome you to our office and will be glad to answer any further questions you might have.

***If the patient is a minor, or legally incapacitated, please obtain the signature of a parent or legal guardian.***

## **SUPPLIES/HOME EQUIPMENT**

Your insurance company may or may not cover certain supplies or home equipment issued to you by our facility. **Supplies** are those items required to carry out a specific treatment order (i.e. electrodes, lumbosacral rolls, instruction booklets, etc.). **Home Exercise Equipment** are those items which may be used to enhance your rehabilitation at home (i.e. theratubing, hand putty, weights, pulleys, etc.).

We try to purchase these items in bulk thus reducing the cost of these items. This savings is then passed on to the patients/insurance companies. We try to keep the pricing of these items extremely fair as we realize the purchase of these items may become the patient's responsibility.

You always have the right to choose whether or not you would like to personally purchase the equipment should your insurance company not cover those items. The supplies, however, are required for your treatment and will be your responsibility should your insurance not cover those items.

Please check with the front desk concerning your insurance coverage. An itemized list of equipment and prices will be shown to you so that you may decide if you would like to purchase the item.

If you have any questions, please do not hesitate to discuss with our office.

Thank you.

I have read and understand the above policy:

\_\_\_\_\_

Signature

\_\_\_\_\_

Date



**SHEA PHYSICAL THERAPY  
HAND THERAPY SERVICES**

January 1, 2019

To our Medicare patients:

Effective January 1, 2019, Congress has permanently extended the current exceptions process for physical and occupational therapy. For the calendar year 2019 this amount is \$2,040.00 for physical and speech therapy services combined and \$2,040.00 for occupational therapy. Therapy claims for outpatient Medicare Part B services that go above \$2,040.00 will require the use of a modifier for attestation that claims are medically necessary which may provide a higher threshold to \$3,000.00.

We will work with you individually to assist in determining your benefits. We will be requesting you to sign this notice (a requirement of Medicare), to acknowledge that we have educated you regarding this benefit. This threshold is for outpatient services only. If it is determined that therapy is “not reasonable and necessary”, you may be requested to pay out of pocket.

We will be closely monitoring our service so we can provide you with the highest quality care available.

Should you have any questions regarding any of this information, please do not hesitate to ask.

Thank you,

*Shea Physical Therapy  
Hand Therapy Services*

---

Patient Signature

---

Date

**SHEA PHYSICAL THERAPY  
HAND THERAPY SERVICES  
Medicare Patients**

1. In the 2019 calendar year, have you received any of the following:

	<b>Circle one</b>	<b>if yes, where?</b>
physical therapy?	yes/no	
occupational therapy?	yes/no	
speech therapy?	yes/no	
home health services?	yes/no	
treatment at an outpatient facility?	yes/no	
seen at a doctor's office?	yes/no	

2. Have you had home assistance for:

	<b>Circle one</b>	<b>if yes, by whom?</b>
bathing?	yes/no	
household chores?	yes/no	
monitoring blood pressure?	yes/no	
administering injections?	yes/no	

3. Have you been hospitalized within the last 30 days? yes/no

If yes, where? \_\_\_\_\_

If yes, for what? \_\_\_\_\_

4. When did you receive any of these previous treatments or assistance?

Start date \_\_\_\_\_ Last date treated \_\_\_\_\_

5. Are you currently receiving home health? yes/no

6. Is a nurse scheduled to see you? yes/no If yes, when? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_