ASCEND HAND THERAPY

Welcome to Ascend Hand Therapy! We look forward to working with you and helping you achieve new heights! Please fill out the form below with the requested information. Please ask for assistance if needed.

Evaluation Date	Clinician	Account Number	Primary/Secondary Ins

Patient Information		
Patient Name (Last, First, Middle)	SSN (Social Security Number)	DOB (Date of Birth)
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Sex ☐ Male ☐ Female	Email Address
Street Address (Mailing Address)	City, State, Zip	Daytime Phone
Referring Physician	When was your last Physician visit? (date)	Work Phone
Was this an Auto Accident? ☐ Yes ☐ No	Work Related Accident? ☐ Yes ☐ No	Date of the Accident?
Attorney's Name & Address (if applicable)		
Emergency Contact	Relation to you?	Emergency Contact Phone Number
Briefly Describe Your Injury or Reason for Treatment		
What is your Goal for Therapy at this Time?		What was the date of your injury?
What was the date of your surgery (if applicable)?	What type of surgery (if applicable)?	

Responsible Party (if same as patient, check here ☐)	
Responsible Party or Business Name (if other than Self)	Phone
Address (City, State, Zip)	Relation to Patient
Insured Party's Social Security Number	Insured Party's DOB

Responsible Party Employer		
Employer's Name	Employer's Address (City, State, Zip)	Employer's Phone

Patient Employer (if same as above, check here ☐)		
Employer's Name	Employer's Address (City, State, Zip)	Employer's Phone

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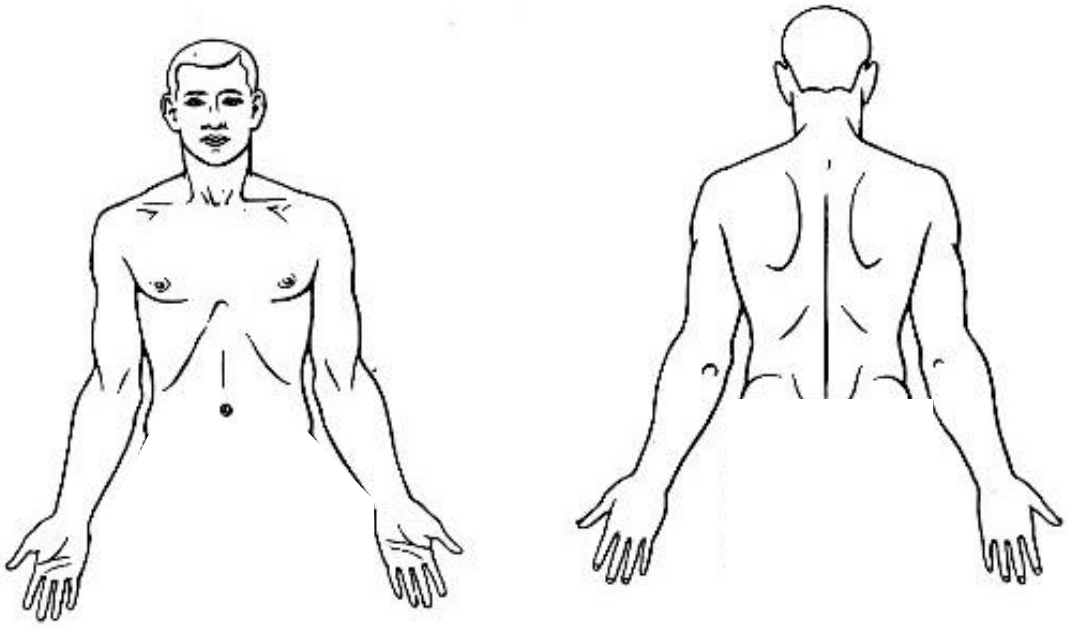
Are you being treated or have you ever been treated for any of the following conditions (check those that apply)?			
Allergies		Hepatitis A, B, C	
Angina		Hernia	
Anxiety or Panic Disorders		High Blood Pressure	
Arthritis (OA, RA, Psoriatic)		Hypoglycemia	
Asthma		Immunosuppressant Condition or Medication	
Back pain		Kidney Problems	
Bleeding Disorders		Liver/Gallbladder Problems	
Bowel/Bladder Abnormalities		Metal Implants	
Cancer		Multiple Sclerosis	
Chronic Obstructive Pulmonary Disorder (COPD)		Nausea/Vomiting	
Congestive Heart Failure (CHF)		Osteoporosis/Osteopenia	
Degenerative Disc Disease (spinal stenosis)		Pacemaker	
Depression		Parkinson's Disease	
Diabetes		Peripheral Vascular Disease	
Dizziness or Fainting Spells		Pregnancy	
Emphysema		Skin Abnormalities	
Epilepsy or Seizure Disorder		Smoking	
Fractures		Stroke or TIA	
Hearing Impaired		Tuberculosis	
Heart Attack		Visual Impairment (cataracts, glaucoma, macular degeneration)	
Other (not listed above), please specify:			

Ascend Hand Therapy ✦ 4897 State Highway 121 ✦ Suite 200 ✦ The Colony ✦ TX ✦ 75056
Phone 469.664.0026 ✦ Fax 469.664.0008
www.ascendhand.com

SYMPTOMS

Please use this diagram to circle any problem areas:



PAIN

On a scale of 0 – 10, circle the number that best describes the intensity of your **worst** pain in the last week.
0 = no pain, to 10 = worst pain you could imagine.

0 1 2 3 4 5 6 7 8 9 10

On a scale of 0 – 10, circle the number that best describes the intensity of your **current** pain.
0 = no pain, to 10 = worst pain you could imagine.

0 1 2 3 4 5 6 7 8 9 10

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Consent for Care and Treatment

I, undersigned, do hereby agree and give my consent for Ascend Hand Therapy, LLC to furnish medical care and treatment to myself/_____ (name, if minor) as considered necessary and proper in evaluating and treating the current physical condition.

_____
Patient or Parent/Guardian Initials

Benefit Assignment/Release of Information

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and third party payers to Ascend Hand Therapy, LLC. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

_____
Patient or Parent/Guardian Initials

Financial Policy Statement

The financial policy of Ascend Hand Therapy, LLC is as follows:

- ◊ We will file and process your insurance claims as a courtesy to you.
- ◊ Copays and coinsurance are due at the time services are rendered.
- ◊ You are ultimately responsible for making sure that a referral and/or authorization (if needed) is on file to avoid claim denials or delays in claim processing. You will be liable for your claims that are denied due to no referral/authorization.
- ◊ We accept Cash, Personal Check with proper ID, VISA, Mastercard, Discover, and American Express.
- ◊ A minimum of $40.00 will be charged to your account for checks returned due to insufficient funds.
- ◊ Cancellation/No Show Policy:
  - *Our office requires a courtesy **24 hour** cancellation advance notice when you are unable to keep your appointment. Unfortunately, whenever an appointment is missed, we are unable to fill the open time slot due to lack of sufficient notice. Our practice charges a **$40.00** fee when the appointment is not cancelled within a **24 hour notice**. We understand that true emergencies happen and in such cases our cancellation policy will not apply, at the discretion of the owners.*
- ◊ Account balances are due upon receipt. Accounts with balances over **60** days will be subject to collections. It is your responsibility to contact our office if you feel there is an error on your account.

_____
Patient or Parent/Guardian Initials

_____ _____
Patient or Parent/Guardian Signature Print Name

_____/_____/_____
Date

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