



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.

| Patient Information | | |
|---|--|-----------------------------------|
| Patient Name (Last, First, Middle) | SSN (Social Security Number) | DOB (Date of Birth) |
| Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | Sex <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | Work Related Accident? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>) | | |
| 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 <input type="checkbox"/>) | | |
| Employer's Name | Employer's Address (City, State, Zip) | Employer's Phone |

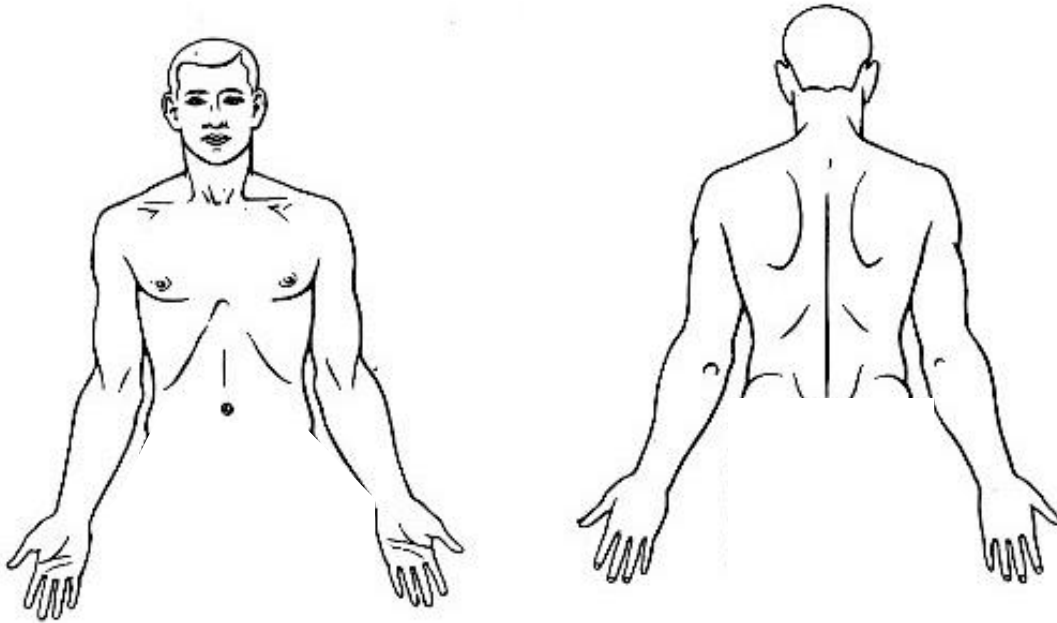


| Are you being treated or have you ever been treated for any of the following conditions (check those that apply)? | | | |
|---|--|---|--|
| Allergies | | Hepatitis A, B, C | |
| Angina | | Hernia | |
| Anxiety or Panic Disorders | | High Blood Pressure | |
| Arthritis (OA, RA, Psoriatic) | | Hypoglycemia | |
| 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: | | | |



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



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. I release any photographs or videos of my treatment, to be used in part, or in its entirety, for the purpose of in-office patient education or any other type of external advertising at the discretion of Ascend Hand Therapy.

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. Accounts sent to collections, incur a 25% increase on all remaining balances. 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