WELCOME TO OUR CLINIC! COVENANT HAND THERAPY, PC

Please take a few minutes to answer the following questions so we can better assist you with your health care and insurance needs.

PATIENT'S NAME _____ **PATIENT'S DATE OF BIRTH** _____

PRIMARY INSURED PERSON _____ **& INSURANCE ID#** _____

& DOB _____ **& EMPLOYER** _____ **& RELATIONSHIP TO PATIENT** _____

INSURANCE CO. NAME _____ **INS. CO. PHONE NUMBER** _____

PLAN GROUP# _____ **PLAN EFFECTIVE DATE** _____ circle: **HMO POS PPO I WC**

If HMO or POS: Primary Care Physician (PCP) Name _____ **Phone** _____

Is a PCP Referral Required? Yes No If yes, insurance referral obtained? Yes No

Referring/Prescribing Doctor _____ Phone _____

Patient's Diagnosis: _____

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 CHT &/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/Guardian Signature _____ ***Date*** _____

CHT staff use:

Occupational & Physical THERAPIES, office setting …… Pre-cert/auth? Yes No Phone _____ Notes

Deductible $_____ Portion Met to Date $_____

_____% Covered with Co-Pay Amount of _____% **OR** $_____/visit

Out of Pocket $_____ Portion Met to Date $_____

OT dollar limit $_____yr OT visit limit_____ Claim Requirements _____

PT dollar limit $_____yr PT visit limit_____ Ins.Rep.Name _____

Calendar Year ☐ or **Plan** Year_____ Are S8950, 29581, 29582, 29583, 29584 covered?

Durable Medical Equipment / orthotics / garments …… Pre-cert/auth? Yes No Phone_____

Deductible $_____ Portion Met to Date $_____ ..…. if over $_____.

_____% Covered with Co-Pay Amount of _____% or $_____/visit

Out of Pocket $_____ Portion Met to Date $_____

Dollar limit for DME $_____yr. Item Limit _____yr Splints… L3808… L3906… L3913 …L3933

Compression Garments: **hose**…A6531…A6533…A6540 **gloves**…A6504…S8425…S8427…S8428 **ReadyWrap…**A6545

Farrow…A6545 **Circaid**…A4465 **Abd binder**…L0625 **Sleeves**…L8010…S8422…S8424 **wraps**… S8429…S8430…S8431

Claim Requirements _____ Ins.Rep.Name_____

Notes _____

_____

_____

INS Call Ref#_____Verified by_____Date/Time_____

COVENANT HAND THERAPY, PC
1101 Ohio Drive, Suite 105, Plano, TX 75093 - phone 972-599-9594 - fax 972-599-9364

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 CHT of any CHT DME equipment failure or damage. • for any CHT equipment that is lost or stolen while in their possession for notifying CHT of such loss. • for notifying CHT of any changes to their address or telephone. • for notifying CHT of any changes concerning their physician. • for notifying CHT of discontinuance of use of issued CHT 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 CHT 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 CHT 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 CHT 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 CHT 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 CHT 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 CHT for any services furnished me by CHT. This authorization applies to all occasions of services until it is revoked.*

Effective October 12, 2009

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

All patients:

Patient/Guardian Signature _____ **Date** _____

COVENANT HAND THERAPY, PC
Please complete entire page.

PATIENT REGISTRATION
Patient Information and Brief Medical History

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ Gender: □ Male □ Female e-mail _____

Social Security Number _____ Marital Status: □ Single □ Married □ Widow(er)

Were you referred to us because of an Accident? □ Auto □ Work □ Other incident □ No

Injury Date and Details _____

Patient's Employer Name & Address _____

In case of Emergency, contact _____ phone number _____

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). Attached additional sheet if necessary.

Have you received any Occupational, Physical, or Speech Therapies, or Chiropractic treatment during this current insurance plan year? □ No □ Yes - how much?

Are you NOW or WITHIN the LAST 60 DAYS receiving home-health care for any reason OR any care at an out-Patient hospital or skilled nursing facility? ☐ No ☐ Yes

If YES, please give name and address of other provider:

Are you presently taking any medications? □ No □ Yes. If yes, please list:

The information above is correct to the best of my knowledge.

Patient/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.

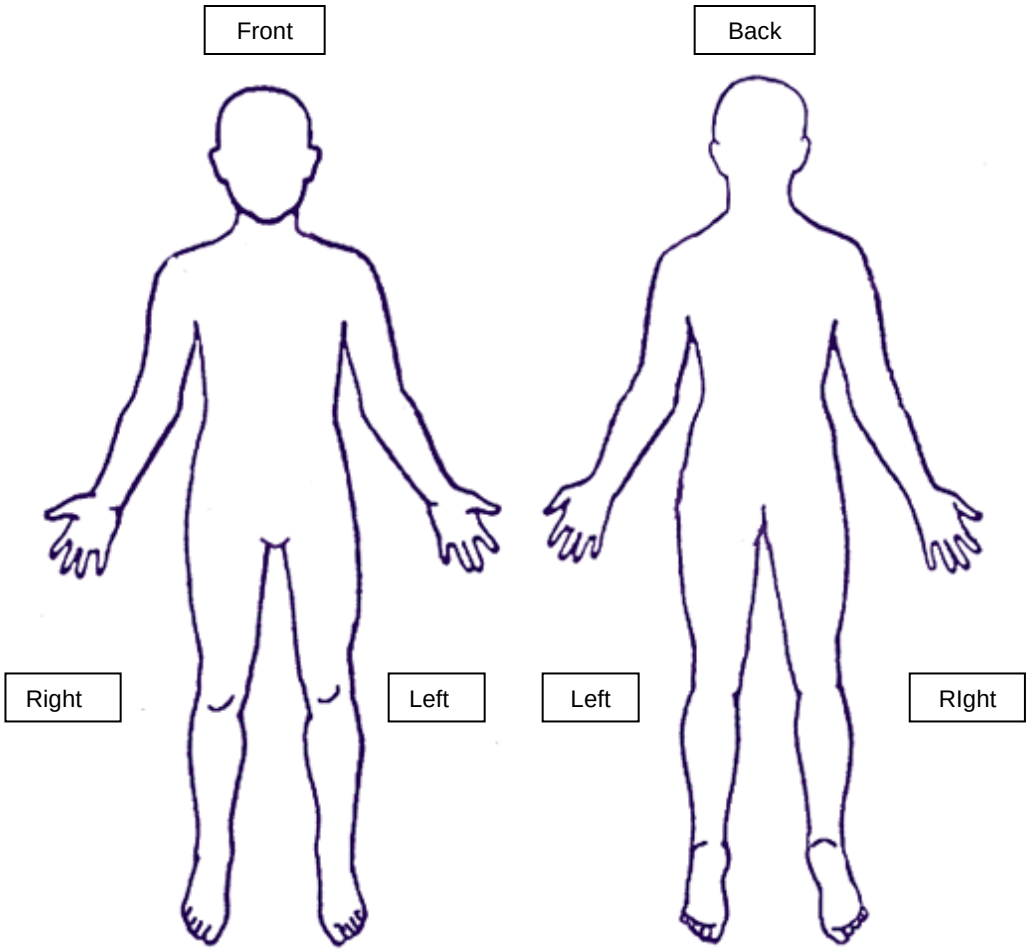
Pain Description

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's Name _____ **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's Printed Name: _____

Patient's 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.

CHT 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: _____

CHT may obtain my information:

I hereby authorize Covenant Hand Therapy, P.C. 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 CHT 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 CHT 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

Covenant Hand Therapy, P.C.
1101 Ohio Dr., Suite 105, Plano, TX 75093
972-599-9594 FAX 972-599-9364

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. CHT 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, check or credit card [American Express, Discover, MasterCard, 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. Patient must notify the clinic by **phone** (clinic voice mail is available 24/7) of cancellation. 972-599-9594 Please do not email or text the clinic or therapist.

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 co-pay at the time of service.

FOR YOUR CONVENIENCE WE ACCEPT CASH, PERSONAL CHECKS, AMERICAN EXPRESS, DISCOVER, MASTERCARD, AND VISA, AS WELL AS CARE CREDIT.

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/Guardian Signature **Date**

Patient PRINTED Name _____

[Policy effective 06/20/2012]