Nevada Hand Therapy

PATIENT DEMOGRAPHIC

Name: _____ **Date of Birth:**_____

Gender: □ Male □ Female

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone:_____
Cell Phone: _____
Work Phone: _____

(In the event Nevada Hand Therapy needs to contact you or leave a message with detailed information, which phone number do you prefer? Please circle.)

We have a reminder call and text service. Would you prefer calls or texts? _____

Referring Physician: _____

Name of Insurance Company: _____ **Phone Number**: _____

I**D#, Claim# or SS#:** _____ **Group #**_____

Guarantor/Policy Holder Name:_____

Employer: _____ Employer Phone Number: _____

Employer Address: _____

Are there any people that we may release personal information (including appointment dates and times, medical information, etc.) to? Please list them: _____

Have you had therapy this calendar year? □ Yes □ No

If YES, how many visits? _____ Where? _____

Is this a worker's compensation claim (work-related injury)? □ Yes □ No

WORK INFORMATION

Are you currently employed? □ Yes □ No

What is your job title?_____ What are your job duties/responsibilities:_____
_____

What is your work status? □ Full-duty □ Light-Duty □ Off-duty □ Restrictions

Patient/Guardian Signature:_____**Date:**_____

Nevada Hand Therapy

PAST MEDICAL HISTORY

Please circle any past or current medical conditions you may have:

Cardiac Heart Failure	Cancer	Stroke
Pacemaker	High Blood Pressure	Head Injury
Cardiovascular Disease	Diabetes	Neck or Back pain
Irregular Heart rate	Arthritis	Pregnancy

Other (please list): _____

Please check if you are a □ non-smoker □ smoker If yes, how many per day? _____

Do you drink? Yes___ No___If yes, how much and how often (drinks per day, drinks per week)? _____

Please list any previous neck, shoulder, arm, and/or hand surgeries and/or injuries: _____
_____
_____
_____

Do you have any metal implants or artificial joints? □ Yes □ No

Please indicate any allergies you may have. □ Steroid □ Adhesives □ Beeswax □ Latex
□ Other allergies, please specify: _____

Are you taking any medications? Please list: _____
_____
_____
_____

Have you had any of the following tests performed for your current injury or problem?

Test			***Results (if known):***
X-rays	□ Yes	□ No	_____
Nerve conduction test	□ Yes	□ No	_____
EMG	□ Yes	□ No	_____
CT Scan	□ Yes	□ No	_____
MRI	□ Yes	□ No	_____

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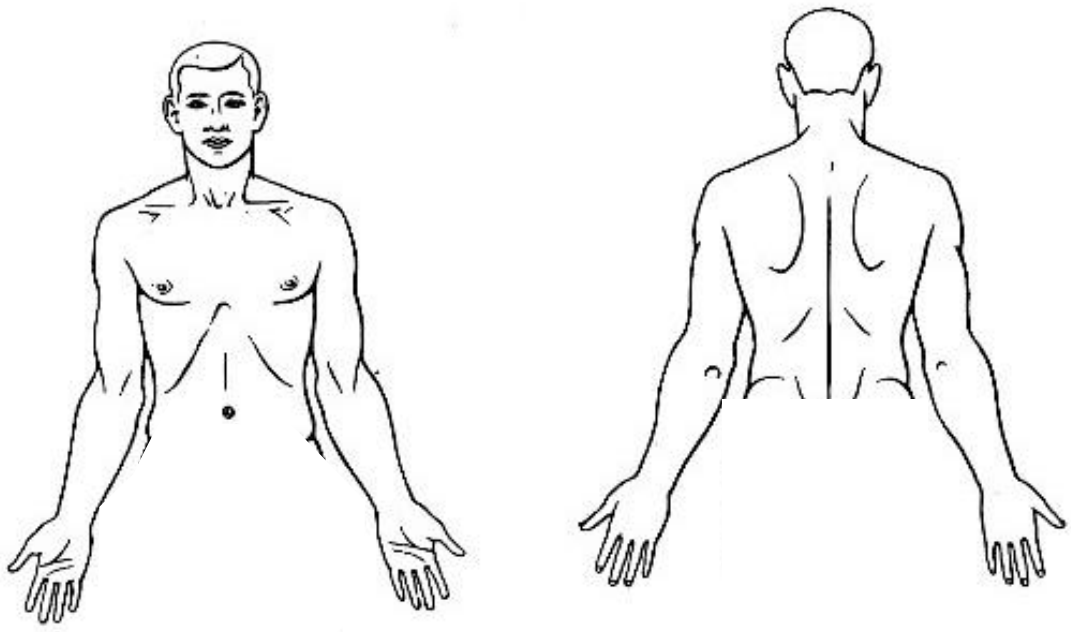
SYMPTOMS

Please use this diagram to circle any problem areas. Use “O” to indicate areas of pain and use “X” to indicate areas of numbness or tingling:



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.

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TELL US ABOUT YOUR CURRENT CONDITION…

What is your diagnosis? _____

Date of injury: _____

Date of surgery (if applicable): _____

What happened? Briefly describe your current problem/symptoms: _____

_____

Have you ever had these symptoms before? When? _____

Any previous treatment for this problem? _____

What postures or activities increase your symptoms? _____

_____

What postures or activities decrease your symptoms? _____

_____

Have you tried any braces and/or splints? _____

How does this impact your life? What can't you do or are you having difficulty as a result of this condition?

_____

What hobbies/recreational activities do you enjoy? Are you having any difficulties performing these activities?

_____

What are your goals in coming to therapy? _____

Is there anything we need to know that is not covered in this form? If yes, please explain below.

_____

Nevada Hand Therapy

Notice of Privacy Practices Patient Receipt

Your signature below acknowledges that you have received a copy of Nevada Hand Therapy's Notice of Privacy Practices. The Notice of Privacy Practices provides you with information about how Nevada Hand Therapy may use or disclose your protected health information. We encourage you to read it in its entirety.

_____ _____

Patient/Guardian Signature **Date**

Understanding of Nevada Hand Therapy Policies

Private Insurance Patients & Medicare Patients

I authorize treatment of the person named and agree to pay all fees and charges for such treatment. I authorize the release of my medical or other information necessary to process my claims. I authorize payment of medical benefits directly to Nevada Hand Therapy, LLC, for services described. Charges shown by statements are agreed to be true and reasonable unless protested in writing within 30 days of the billing date.

_____ _____

Patient/Guardian Signature **Date**

Worker's Compensation Patients

I authorize the release of my medical or other information necessary to process my claims. Nevada Hand Therapy, LLC, will bill your worker's compensation carrier for your charges. However, if for any reason your claim is denied, then you will become financially responsible for your bill. Worker's Compensation patients who have numerous NO CALL/NO SHOW appointments and collations without giving 24-hour notice may result in a denied claim from your Worker's Compensation Insurance Company.

_____ _____

Patient/Guardian Signature **Date**

Center for Medicare Services (CMS): Medicare Limits on Therapy Services

For calendar year 2016, the CMS (Center for Medicare & Medicaid Services) policy for outpatient occupational therapy cap is $1960. This financial cap is separate from physical therapy and speech-language therapy. If occupational therapy services exceed this $1960. cap and exceptions beyond this financial limit, the remaining balance will be the patient's responsibility. Medicare does allow certain diagnoses to go beyond the standard cap. For more information about this, please contact our front desk. For more information on Medicare Part B outpatient therapy caps and the exceptions process, visit http://www.cms.gov/.

_____ _____

Patient/Guardian Signature **Date**

Nevada Hand Therapy

24-Hour Cancellation Policy

At Nevada Hand Therapy, we strive to maintain appointment schedule time, reduce unnecessary wait times, and allow patients to be seen quickly after a physician refers them to us. One of the factors which strongly influences our ability to do this is the failure of patients to show for scheduled appointments without adequate cancellation notice. We require **24 hour** notice of cancellation so that we may give your appointment time to another patient who may need it. If you know that you cannot make your scheduled appointment, please call us to let us know. We understand that occasionally there may be unavoidable circumstances that cause you to miss your appointment. These will be evaluated on a case by case basis.

WORKER'S COMPENSATION PATIENTS
We reserve the right to notify your claims adjuster, case manager, and/or physician after **THREE MISSED APPOINTMENTS WITHOUT 24 HOURS NOTICE.** We may also cancel all future appointments until you have returned to your physician for a new prescription.

PRIVATE PATIENTS
We reserve the right to bill you **$40.00** for a missed appointment if we are not given **24 hours** notice.

Again, we realize that there are emergencies and unavoidable circumstances that may cause you to miss your appointment without being able to give us 24 hours notice. We will evaluate these situations on a case by case basis and will consider waiving the cancellation fee if certain criteria are met.

Your signature below indicates that you have read a copy of our 24-hour cancellation policy.

_____ _____

Patient/Guardian Signature **Date**

THE QuickDASH OUTCOME MEASURE

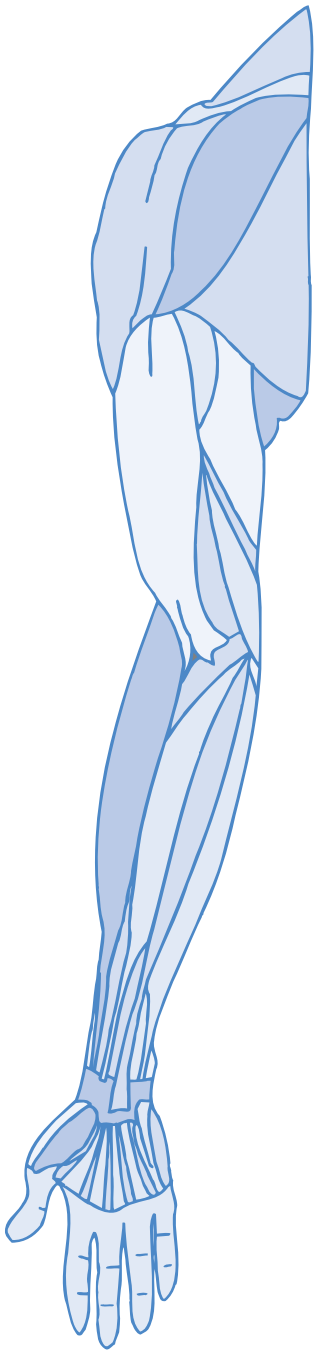
INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.



*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❒ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

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