APEX HAND THERAPY, LLC

Workers' Compensation - Patient Registration Form

PLEASE PRINT & FILL FORM COMPLETELY

PATIENT DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER (SSN)	DATE OF BIRTH	GENDER
		☐ Male ☐ Female

MARITAL STATUS	OCCUPATION
☐Single ☐Married ☐Divorced ☐Widowed	

HOME – STREET NAME & NUMBER	CITY, STATE & ZIP CODE

EMPLOYER NAME	EMPLOYER ADDRESS

PLEASE ENTER PARENT OR GUARDIAN DEMOGRAPHIC & CONTACT INFORMATION IF PATIENT IS A MINOR

PARENT OR GUARDIAN DEMOGRAPHIC INFORMATION

☐ NOT APPLICABLE

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER (SSN)	DATE OF BIRTH	GENDER
		☐ Male ☐ Female

OCCUPATION	RELATIONSHIP TO PATIENT

HOME – STREET NAME & NUMBER	CITY, STATE & ZIP CODE

EMPLOYER NAME	EMPLOYER ADDRESS

PATIENT OR RESPONSIBLE PARTY CONTACT INFORMATION

PHONE NUMBERS

HOME:	CELL:
WORK:	OTHER:

EMAIL ADDRESS

PRIMARY:

SECONDARY:

EMAIL CONSENT – REQUIRED FOR HIPAA COMPLIANCE

I ______________________________________, _______________ give permission to Apex Hand Therapy, LLC to communicate with me via Email, regarding appointments, statements & treatment.

Signature:____ Date:______________________

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP

PHONE NUMBERS

HOME:	CELL:
WORK:	OTHER:

HOME – STREET NAME & NUMBER	CITY, STATE & ZIP CODE

THE ABOVE INFORMATION IS STRICTLY CONFIDENTIAL AND WILL BE USED FOR MEDICAL PURPOSES ONLY

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APEX HAND THERAPY, LLC

Workers' Compensation Information

PATIENT FULL NAME: ____

WORKERS' COMPENSATION INFORMATION

☐ **NOT APPLICABLE**

NAME OF WORKERS' COMPENSATION CARRIER	CLAIM NUMBER

WORKERS' COMPENSATION CARRIER ADDRESS	CITY, STATE & ZIP CODE

WORKERS' COMP PHONE NUMBER	WORKERS' COMP FAX NUMBER

ADJUSTER'S NAME	PHONE NUMBER	FAX NUMBER

CASE MANAGER'S NAME	PHONE NUMBER	FAX NUMBER

EMPLOYER AT THE TIME OF INJURY	CONTACT PERSON NAME

CONTACT PERSON - PHONE NUMBER	CONTACT PERSON - FAX NUMBER

EMPLOYER – STREET NAME & NUMBER	CITY, STATE & ZIP CODE

LITIGATION INFORMATION

ATTORNEY'S NAME (IF A LAWSUIT IS INVOLVED)	ATTORNEY'S OFFICE NAME

PHONE NUMBER	FAX NUMBER

ATTORNEY'S OFFICE – STREET NAME & NUMBER	CITY, STATE & ZIP CODE

NOTICE TO WORKERS' COMPENSATION PATIENTS

In the event that Workers' Compensation denies your claim and you plan to use your health insurance to pay for your care, be advised that if your health insurance company requires a PCP referral and you have not obtained one, the insurance company can deny payment. If your health insurance company denies payment, you will be responsible for payment in full for the services & equipment provided.

ASK THE STAFF IF THIS NOTICE APPLIES TO YOU. IF THIS NOTICE DOES NOT APPLY TO YOU, HAVE IT STRUCK & STAMPED.

______________________________________ ____________________

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**

FOR APEX HAND THERAPY INTERNAL USE ONLY

Strike off & Stamp the above notice if it does not apply to this patient & please document the date and time.

______________________________________ ____________________

STAFF NAME & SIGNATURE || TIME DATE

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APEX HAND THERAPY, LLC
Disclaimer - I

PATIENT FULL NAME: ______________________________

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY

I know and agree that APEX HAND THERAPY, LLC is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE

I hereby release, discharge and acquit APEX HAND THERAPY, LLC, it's agent's, representatives, Affiliate's, employees, or assigns, of and from any and liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

APPOINTMENT CANCELLATION NOTICE

I understand and acknowledge that Apex Hand Therapy, LLC requires 24-hour cancellation notice for appointments and that a $ 25.00 per 15 minutes fee will be charged for being late for appointments, missed appointments and appointments not cancelled 24 hours prior to scheduled appointment time.

MEDICAL RECORDS

For copies or release of any and all medical records, we require a $ 10.00 service fee + 50 cents per page in addition to signing the medical records release form.

For electronic medical records, we require a $ 15.00 fee in addition to signing the medical records release form.

Medical records will be released only after full payment.

IMPORTANT SPLINT/ORTHOTICS INFORMATION

At APEX HAND THERAPY, LLC we make splints that are custom fabricated to specifically fit you. The splints we fabricate are made for you and your condition per your doctor's orders. Because the splint is custom made there are NO RETURNS OR REIMBURSEMENTS, as they cannot be used for anyone else. There are NO RETURNS OR REIMBURSEMENTS FOR MODIFIED PREFABRICATED (non-custom made) SPLINTS. NON-MODIFIED PREFABRICATED splints have a 5-day return policy. The non-modified prefabricated splints must be returned WITH THE ORIGINAL PACKAGING & IN NEW CONDITION. **It will be the patient's responsibility to cover the cost of replacing the (lost, stolen, or destroyed) splint.**

BENEFIT RELEASE AND AUTHORIZATION OF PAYMENT

I, the undersigned, authorize the release of any medical information relating to all claims for benefits submitted on behalf of my dependent or myself. I further agree and acknowledge that my signature on this document authorizes Apex Hand Therapy, LLC to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for my dependent or myself. I hereby assign directly to Apex Hand Therapy, LLC all insurance benefits, if any, and otherwise payable to me for services rendered. Photo static copy of this authorization shall be considered as effective and valid as the original.

I have read and understand all of the above disclaimers.

______________________________ ______________________

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

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APEX HAND THERAPY, LLC
Disclaimer - II

PATIENT FULL NAME: ______________________________

HIPAA & NOTICE OF PRIVACY

I have been directed to read our Notice of Privacy Practices. I understand that Apex Hand Therapy, LLC 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.

______________________________ ______________
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

PATIENT RIGHTS & 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.
- To confidentiality of all information pertaining to his/her service (subject to applicable law). [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 Apex Hand Therapy, LLC of any Apex Hand Therapy, LLC DME equipment failure or damage.
- For any Apex Hand Therapy, LLC equipment that is lost or stolen while in their possession for notifying Apex Hand Therapy, LLC of such loss.
- For notifying Apex Hand Therapy, LLC of any changes to their address or telephone.
- For notifying Apex Hand Therapy, LLC of any changes concerning their physician.
- For notifying Apex Hand Therapy, LLC of discontinuance of use of issued Apex Hand Therapy, LLC equipment.

I AUTHORIZE APEX HAND THERAPY, LLC TO:

- ☐ Leave messages concerning my appointment time at home / work / cell phones.
- ☐ Allow my appointment time to be scheduled, cancelled, or rescheduled by my spouse/ ______________
- ☐ Accept payment or discuss payment arrangements on my account with my spouse/ ______________
- ☐ Leave messages concerning payment at home / work / cell phones.
- ☐ OTHER ______________________________

______________________________ ______________
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

FOR APEX HAND THERAPY INTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice of privacy policy, please document the date and time the notice was presented to patient and sign below.

OTHER NOTE: ______________________________

____

____

______________________________ ______________
STAFF NAME & SIGNATURE || TIME DATE

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APEX HAND THERAPY, LLC
Patient Medical History - I
PLEASE PRINT

PATIENT FULL NAME: ______________________________

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)					
CONDITION	**YES**	**NO**	**CONDITION**	**YES**	**NO**
Heart Problems or Angina	☐	☐	Bowel or Bladder Problems	☐	☐
High Blood Pressure	☐	☐	Cancer/Tumor (Specify Below)	☐	☐
Is your blood pressure under control?	☐	☐	Had Chemotherapy or Radiation (Specify Below)	☐	☐
Shortness of Breath or Chest Pain	☐	☐	Infections (Specify)	☐	☐
Heart Attack or Heart Surgery (Specify Below)	☐	☐	Infectious Diseases (Specify Below)	☐	☐
Stroke or TIA (Specify Below)	☐	☐	Pins, Plates, Screws Implanted (Specify Below)	☐	☐
Blood Clot or Emboli (Specify Below)	☐	☐	Joint Replacement(s) (Specify Below)	☐	☐
Epilepsy or Seizures (Specify Below)	☐	☐	Arthritis or Swollen Joints (Specify Below)	☐	☐
Psychological/Psychiatric Problems (Specify)	☐	☐	Osteoporosis	☐	☐
Sleep problems or Difficulties (Specify)	☐	☐	**OPEN WOUNDS (SPECIFY BELOW)**	☐	☐
Frequent or Severe Headaches (Specify)	☐	☐	SURGERIES (SPECIFY BELOW)	☐	☐
Dizziness or Fainting (Specify Below)	☐	☐	OTHER CONDITIONS (SPECIFY BELOW)	☐	☐
Vision or Hearing Problems (Specify Below)	☐	☐	**ARE YOU PREGNANT?**	☐	☐
Thyroid Problems or Goiter	☐	☐	**DIABETES**	☐	☐
Do you Smoke?	☐	☐	**PACEMAKER**	☐	☐
Do you Drink Alcohol?	☐	☐	**OTHER IMPLANTS (SPECIFY BELOW)**	☐	☐
Weight Loss or Loss of Energy or Weakness	☐	☐	**TINGLING (SPECIFY BELOW)**	☐	☐
Anemia	☐	☐	**NUMBNESS (SPECIFY BELOW)**	☐	☐
Asthma, Bronchitis or Emphysema	☐	☐	**ALLERGIES (SPECIFY BELOW)**	☐	☐
AIDS (HIV)	☐	☐	**LATEX ALLERGY**	☐	☐

SPECIFY:

LIST ALL MEDICATIONS (BOTH PRESCRIPTION & OVER THE COUNTER)			
MEDICATION TYPE	**MEDICATION NAME**	**PILL SIZE (e.g. 5 mg)**	**DOSAGE**
Pain Relievers			
Anti Inflammatory			
Muscle Relaxants			

LIST ALL INPATIENT & OUTPATIENT SURGICAL ADMISSIONS

HOW IS YOUR GENERAL HEALTH? ☐ **POOR** ☐ **FAIR** ☐ **GOOD** ☐ **EXCELLENT**

______________________________ ______________________________

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

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APEX HAND THERAPY, LLC

Patient Medical History - II

PLEASE PRINT

PATIENT FULL NAME: ____

REFERRING PHYSICIAN NAME	PHONE NUMBER	HAND DOMINANCE
		☐ RIGHT ☐ LEFT

DIAGNOSIS	TYPE OF SURGERY	DATE OF SURGERY
☐ Right ☐ Left	☐ Right ☐ Left	

THIS INJURY/ACCIDENT IS RELATED TO:	DATE OF INJURY/ACCIDENT:
☐ WORK ☐AUTO ACCIDENT ☐OTHER (SPECIFY)	

ARE YOU CURRENTLY WORKING?	IF YES, DUTY TYPE
☐ YES ☐ NO	☐ REGULAR DUTY ☐ MODIFIED DUTY

EXTREMITY BEING TREATED	☐ RIGHT ☐ LEFT
☐FINGER ☐THUMB ☐HAND ☐WRIST ☐FORE ARM ☐ELBOW ☐ARM ☐SHOULDER	

HOW DID YOUR INJURY HAPPEN?

REASON FOR ATTENDING THERAPY (CHECK ALL THAT APPLY)			
☐ JOINT STIFFNESS	☐ WEAKNESS	☐ PAIN	☐ DIFFICULTY IN DAILY ACTIVITIES

PAIN LOCATION	TYPE OF PAIN	RATE PAIN ON A 0 - 10 SCALE
1- 2- 3-	1- 2- 3-	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

WHAT ACTIVITIES ARE MOST DIFFICULT BECAUSE OF YOUR PROBLEM?

WHAT ARE YOUR TREATMENT GOALS?

CONSENT TO TREATMENT

The above information is accurate to my knowledge.

My diagnosis, the evaluation findings, the provider recommendations regarding treatment, the expected benefits or goals of treatment and the reasonable alternatives to recommended treatment have all been explained to me; and my questions about care have been answered to my satisfaction.

I hereby voluntarily consent to receive treatment for my dependent or myself. I understand that a properly credentialed clinician of Apex Hand Therapy, LLC and in accordance with the law will perform my treatment. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I further understand that I may rescind my consent at any time and will be informed of the potential consequences of that decision.

PATIENT OR LEGAL GUARDIAN SIGNATURE	DATE	THERAPIST SIGNATURE

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THE *Quick*DASH

OUTCOME MEASURE

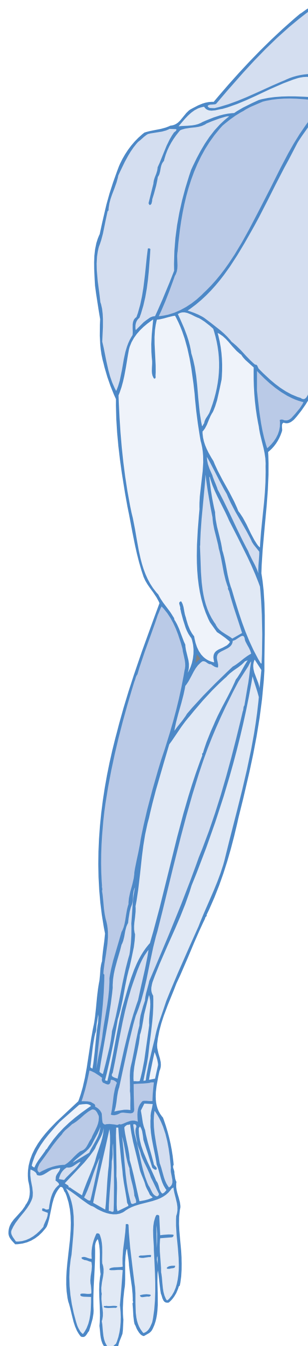
INSTRUCTIONS

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 not be calculated if there are any missing items.

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Brief ICF Core Set for Hand Conditions

Check Applicable Codes

ICF code	Title
b152	Emotional functions
b265	Touch function
b270	Sensory functions related to temperature and other stimuli
b280	Sensation of pain
b710	Mobility of joint functions
b715	Stability of joint functions
b730	Muscle power functions
b760	Control of voluntary movement functions
b810	Protective functions of the skin
s120	Spinal cord and related structures
s720	Structure of shoulder region
s730	Structure of upper extremity
d230	Carrying out daily routine
d430	Lifting and carrying objects
d440	Fine hand use
d445	Hand and arm use
d5	Self-care
d6	Domestic life
d7	Interpersonal interactions and relationships
d840 - d859	Work and employment
e1	Products and technology
e3	Support and relationships
e5	Services, systems and policies