apexhandtherapy.com
bharat@apexhandtherapy.com

APEX HAND THERAPY

Hand, Wrist, Elbow & Shoulder Rehabilitation

TEL: (703) 242 – 4263
FAX: (855) 802 – 9786

M-F – 9:00 AM - 5:00 PM
SAT - 9:00 AM - 12:00 PM

226 MAPLE AVE W, SUITE 405
VIENNA, VA 22180

Dear Patient,

Thank you for choosing Apex Hand Therapy for your medical care. Enclosed you will find the required paperwork. Please take time to review and complete each form carefully prior to your appointment. **We participate with Carefirst, Anthem, FEP, All BCBS & Cigna PPO plans ONLY.** Please bring your insurance card(s), valid ID & PHYSICIAN REFERRAL for your first appointment. Also, bring your X-Rays and other relevant information that you may have. **Medicare requires all therapy and orthoses/splints to be prescribed by physicians and not by physician assistants and nurses.**

Please note that Medicare is denying payments or retro-actively denying payments for all hand/upper limb orthosis/splints, if you had an orthosis fabricated in the past five years irrespective of the side or purpose/diagnosis of the splint/orthosis. You will have to pay for the orthosis/splint your self, even thought the physician prescribed one for a different side or purpose/diagnosis.

It is the goal of our office to provide you with the best possible care and to make sure we have allowed the appropriate amount of time required for your visit. If for any reason you are unable to arrive at the scheduled time for any of the visits, it may become necessary to reschedule your appointment. We are located in a high traffic area. Please allow yourself plenty of time to arrive on time for your appointment. If you need directions, please feel free to contact us and we will do our best to provide additional directions to you.

We treat one patient at a time, unlike other therapy practices that accept health insurances. When you schedule an appointment with our practice, that time is reserved for you. When you miss the appointment without calling to cancel within a reasonable amount of time, your practitioner does not have the opportunity to offer that time to someone else in need of services. Missed appointments can also interfere with your progress in treatment. It is our policy that patients are responsible for all appointments that they have scheduled. You may choose to receive phone/voice, email and text message reminders**.** $80 fee will be charged each time you fail to give us 24 hours advanced notice (between Monday – Friday during business hours & excluding holidays**)** & for late arrivals (10 minutes past the scheduled appointment time)**.** Insurance does not cover this fee. Any exceptional circumstances will be submitted for review.

We use a billing service to process your insurance claims. If at any time during or after your care you are not satisfied with the billing service, you may directly contact me. <u>We will greatly appreciate if you can take time to write a Google review after completion of your care.</u> Plese do not write a Yelp review as their marketing dept. will bombard us wth calls after every review. Again, thank you for choosing us for your medical care.

Sincerely,

Bharat Vallurupalli

Apex Hand Therapy

PATIENT/GUARDIAN FULL NAME:_____

SIGNATURE:_____

APEX HAND THERAPY

Patient Registration Forms

PLEASE PRINT LEGIBLY & 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 / GUARDIAN / RESPONSIBLE PARTY'S DEMOGRAPHIC & CONTACT INFORMATION

INSURANCE SUBSCRIBER DEMOGRAPHIC INFORMATION

☐ SAME AS ABOVE

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: ( ) -

- E-MAIL ADDRESS IS REQUIRED AS STATEMENTS WILL BE EITHER E-MAILED &/OR TEXTED.

- THERE WILL BE A $5 FEE FOR EACH MAILED STATEMENT.

E-Mail for Reminders and Statements/Statement Links:

Number for Text Reminders and Statement Links:

EMAIL & TEXTING CONSENT – REQUIRED FOR HIPAA COMPLIANCE

I _____, give permission to Apex Hand Therapy to communicate with me via Email or text 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

APEX HAND THERAPY

INSURANCE DISCLAIMER

All insurance information, not limited to primary, secondary or tertiary, must be disclosed at the initial visit. Failure to give complete and accurate information may result in non-covered services and/or non-billed claims filed to your insurance company due to claim filing limitations and authorization for services. I have read and understand this information and all information. I certify that all insurance information I provided is true and accurate.

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 is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE

I hereby release, discharge and acquit APEX HAND THERAPY, 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 requires 24-hour cancellation notice for appointments and that a $ 80.00 fee will be charged for arriving late (10 minutes or more), missed appointments and appointments not cancelled or rescheduled 24 hours prior to the scheduled appointment time.

BENEFIT RELEASE AND AUTHORIZATION OF PAYMENT

I understand that explanation of coverage will be obtained from my insurance company as a courtesy and it's not a guarantee of coverage. I do not hold APEX HAND THERAPY and/or it's affiliates responsible for any incorrect or omitted or for any charges in my future coverage. If coverage is not a direct contract or if the information provided by my insurance company is not accurate or the insurance company changes it's coverage, I agree, I will be fully responsible for payment for services. I understand that I can verify this information by reading my insurance book or contacting my insurance company.

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 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 all insurance benefits, if any, and otherwise payable to me for services rendered. I understand fully that I in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for all charges incurred. If my account is turned over for collection, I agree to pay all costs of collection, including a reasonable attorney fee. Photo static or scanned copy of this authorization shall be considered as effective and valid as the original.

HIPAA & NOTICE OF PRIVACY

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

I AUTHORIZE APEX HAND THERAPY 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 _____

I have read and understand all of the above policies & disclaimers.

PATIENT OR LEGAL GUARDIAN NAME _____

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

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

APEX HAND THERAPY

PATIENT RIGHTS & RESPONSIBILITIES

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.

PATIENT IS RESPONSIBLE:
- To notify of any DME equipment failure or damage.
- To notify us of equipment that is lost or stolen while in their possession..
- To notify any changes concerning their physician.
- To notify any changes including name, address, phone number, employment.
- To know his/her health plan benefits.
- To pay the bills.
- To treat clinic providers, staff and other patients with dignity, respect, and courtesy.

FINANCIAL LIABILITY

We are committed to providing you with the highest level of customer service and quality medical care. We encourage your feedback to make every visit a positive experience. We will gladly file insurance claims as a courtesy to you; however, ANY AND ALL FINANCIAL LIABILITY ULTIMATELY RESTS WITH THE PATIENT.

COPAY / COINSURANCE / DEDUCTIBLE

We do not collect copay / coinsurance / deductible at the time of the visit as it may be different in the Explanation Of Benefits (EOB) (from what the insurance may say at the time we verify your benefits). We accept credit cards, check & cash payments. There will be a $ 35.00 returned check fee on all returned checks.

PRIMARY CARE PHYSICIAN (PCP) REFERRAL

IF YOUR INSURANCE PLAN REQUIRES A REFERRAL (AT INITIAL APPOINTMENT AND/OR FOR SUBSEQUENT APPOINTMENTS), THE REFERRAL MUST BE PROVIDED TO US BEFORE BEING TREATED BY THE THERAPIST. IF YOU DO NOT PROVIDE US WITH A REFERRAL ON TIME, YOU WILL BE LIABLE FOR ALL DENIED CLAIM CHARGES.

MEDICAL RECORDS

We require a $ 10.00 service fee + 50 cents per page in addition to signing the medical records release form for faxed medical records.
We require a $ 15.00 fee in addition to signing the medical records release form for electronic (e-mailed or CD) medical records.

PAYMENT

We expect prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please speak with our billing manager to set up a payment plan. In the event that your account is turned over to a lawyer or collection agency, in addition to the principal balance owed, you will be responsible for any interest incurred plus any and all sfees.

ALL SELF PAYING PATIENTS MUST PAY AT THE TIME OF SERVICE USING CHECK or CASH.

I have read and understand the above outlined policies & disclaimers.

PATIENT OR LEGAL GUARDIAN NAME _____

_____ _____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

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**

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

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-	1-	☐1 ☐2 ☐3 ☐4 ☐5
2-	2-	
3-	3-	☐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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*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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