Outpatient Agreement Form

General Policy: All patients shall be treated without discrimination related to age, race, ethnicity, religion, culture, language, physical or mental disability, social or economic status, gender, sexual orientation, or gender identity or expression.

Consent for Treatment: I or my representative agree to have Hands On Therapy providers evaluate and treat my condition. I understand that occupational therapy is not an exact science and that no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations or treatments or other healthcare services including provision of durable medical equipment

Authorization and Assignment of Benefits:

I hereby authorize Hands On Therapy, LLC to apply for benefits from my insurance Carrier(s) listed and further authorize payment directly to, Hands On Therapy, LLC of the medical benefits, if any, otherwise payable to me for services rendered by Hands On Therapy, LLC in office and/or through telehealth services. I agree that payment form my health plan may go directly to Hands On Therapy. If I should receive the payments, I understand that I will be responsible for paying Hands On Therapy, LLC

Medicare Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Hands On Therapy, LLC for my services furnished to me by Hands On Therapy, LLC. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I Hereby authorize Hands On Therapy, LLC to administer any treatment as may be deemed necessary and advisable in the diagnosis and treatment of *Patient*. Further, I authorize Hands On Therapy, LLC to disclose complete information concerning records regarding the illness or accident of *Patient* to any collateral source in the case of Medicare, the Social Security Administration and the Health Care Financing Administration that will pay part of or all of said medical bills. I hereby waive on my behalf of myself and any persons who may have an interest in the matter all provisions of law relating to disclose of confidential medical information.

I understand that all bills for services are due from me when rendered, and I am completely responsible for these charges regardless of any third-party interest, payer or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Hands On Therapy, LLC reserves the right to pursue delinquent accounts via third-party collection agencies or attorneys. In the event my bill is referred to collection, I agree to pay all collection fees(33%), the pre-judgement interest of 1.5% per month (18% per year), all attorney fees and court costs and service of process costs to occupational therapist in addition to the amount owed for the services rendered and a $15 late fee per month not to exceed $45. Additionally, there will be a $20 return check/payment fee. This agreement is a contract under seal and shall be considered binding.

This Authorization and Assignment of Benefits is valid for all episodes of care rendered by any and all physical or occupational therapists and/or physical or occupational therapy assistants associated with Hands On Therapy, LLC.

PATIENT NAME:_____

Notice Of Privacy Practices

In accordance with HIPAA privacy regulations, we are notifying you as to how medical/protected health information about you may be used and disclosed.

Under the law, we are required to maintain the privacy of this information, but may need to share protected health information (PHI) to others in order to process your claim or for health care operations, which may include but are not limited to: 1) Receive Payment, 2) Verify Insurance, 3) Conduct Quality Assessment, 4) Care Coordination/Management, 5) Manage our Business, 6) Assist Other Covered Entities With Their Health or Business Operations, 7) Accreditation, Certification, Licensing or Credentialing. 8) Disclosure to the Secretary of the United States Department of Health & Social Services, 9) Health Oversight Agencies, 10) To prevent a serious threat to Health or Safety, 11) Research, 12) Workman's Compensation, 13) Public Health & Safety, 14) Legal, National Security or Law Enforcement, 15) Personal Physician, Team Physician, Athletic Director or Coach, 16) To you or your Designee upon written request, 17) Other uses and disclosures of PHI only after your written authorization.

All Evaluations, Progress Notes as well as significant changes in Medical Conditions will be reported via Fax, Text, Phone, and/or Mail to your referring Physician and possibly Primary Care Physician. All insurances will be verified with pertinent PHI being released to the Insurance Company(s) necessary to process claims. All patients will be asked to sign in at the front desk upon arrival and names will be announced. Evaluation and treatment is performed in an open environment. Some claims are billed electronically. If you wish not to sign in on the sheet, not to have your name announced, not to bill claims electronically, or not to be in an open area for treatment, please notify the receptionist immediately and we will attempt to make alterations to accommodate your needs. If you have any questions, please ask to speak to the clinic director.

XSignature_____Printed Name:_____ Relationship to Pt:_____Date_____

Hands On Therapy Staff: I understand that all the staff may not be employees of Hands On Therapy, LLC. I understand that my therapist may ask other providers to participate in my care including but not limited to physicians and therapists. I also agree that students or other personnel may participate in and or observe my care unless I specifically state otherwise verbally or in writing.

Payment for services:I authorize direct payment to Hands On Therapy, LLC of any insurance, personal injury or other benefits otherwise payable to me or the patient. I acknowledge the financial responsibility for any coinsurance, deductible or other sum not received by Hands On Therapy, LLC from any third party source for the care and services rendered to patient. I assign my right to appeal a denial of payment to Hands On Therapy, LLC for services rendered to me.

I understand that Hands On Therapy, LLC may be treated as an out of network provider by my health plan for services rendered by Hands On Therapy, LLC. In such case, my copay or deductible may be greater than if services were rendered at an in network facility. I understand that I must pay any copayment or other part of the bill that my health plan says I must pay including a higher deductible or copay as a result of out of network benefit. I know that I may need to pay this before I am treated.

Personal Belongings: Patients are responsible for their personal belongings. Hands On Therapy, LLC shall not be responsible or liable for the loss of or damage to any personal property including damage to vehicles on the parking lot.

Cancellation/No Show policy: 24 hours notice is required if you are unable to keep a scheduled appointment. There will be a $30 cancellation fee if you do not show for your scheduled appointment, or if you cancel on the same day as your appointment. If you do not show for your scheduled appointment 2x in a row, your future appointments may be removed from the schedule and your physician and insurance company may be notified. Your insurance company *does not* pay this fee and payment will be expected prior to your next visit.

Inclement Weather Policy: In the case of bad weather, please call the office or send an email to let us know if you will be canceling your appointment. All offices follow Baltimore County school delays and closures. However, if the office will be open someone will contact you to confirm your appointment

Referral and Prescription Policy: It is your responsibility to keep track of the number of visits allowed and the valid period of each referral and prescription. Failure to do so may result in treatment that was not authorized by your insurance carrier and any charges incurred for these unauthorized visits would be your full responsibility.

Consent to be contacted: I agree that by providing my landline, cell phone number(s) and email address, I am giving express consent for Hands On Therapy, it's staff, employees, independent contractors, assignees, successors and agents to contact me at these numbers or any number that is later acquired for me and to leave live or pre-recorded messages or text messages regarding my healthcare-related matters, my account or my bill related to services I receive. I confirm that any phone number I provide is associated with me and not a third-party. Providing a telephone or cell phone number is not a condition of receiving services.

Email Address: _____

Text: _____(cell carrier) □Verizon □AT&T □Tmobile □Sprint □Other_____

I prefer appointment reminders be sent by (check one) email____ OR text _____ (Carrier charges may apply, please check with your carrier).

Safety: I agree to wash my hands for 20 seconds prior to entering the clinic. I also agree to don a mask covering my nose and mouth for the duration of my visit in the facility. I agree to have my temperature taken upon entering clinic. I agree to cancel my visit if I have a fever or if I have been in close contact with a positive COVID patient for an extended period of time and have not completed 14 days of isolation. I agree that only patients are permitted in the building and others will wait outside. In the case of a minor, one adult needs to accompany the minor during treatment. Please see the front office if any accommodations need to be made.

XSignature_____Printed Name:_____ Relationship to Pt:_____Date_____

Payment Policy: Copays or fees for service including deductibles, are due and payable at the time of service. We accept cash, checks and credit cards. We now have a touchless system for all our checkin procedures. For safety, we will keep a payment source (credit card/bank info) on file which can be used to pay any copays, coinsurances deductibles. If at any time you wish to change your method of payment please inform the office. Additionally, if you prefer to use an alternate payment method for you appointment you can log on to **www.handsontherapy.net** to make your payment *prior* to your visit. Your estimated amount per visit will be:_____. Additionally, If you have a deductible that has not been met. You will be responsible for paying $100 towards the cost of the deductible each visit until it's met.

By signing below, I authorize Hands On Therapy, LLC to keep my signature and my credit card information securely on-file in my account. I authorize Hands On Therapy, LLC to charge my credit card for any outstanding balances when due. This authorization is valid until I provide written cancellation in the form of an email or letter to Hands On Therapy, LLC 11 Keller Road Baltimore MD 21208

If the credit card that I have today changes, expires, or is denied for any reason, I agree to immediately give Hands on Therapy, LLC a new, valid credit card which I will allow them to charge over the telephone. Even though Hands On Therapy, LLC is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

☐ Visa ☐Mastercard ☐Discover ☐American Express ☐Other_____

Patients Name (print):_____ DOB:_____

Name on Card (print):_____

Last Four Digits of Credit Card:_____. Billing Zipcode:_____Exp. Date: _____

Credit Card Holder's Signature:_____ Date: _____

Safety Precautions:

Have you had a fever (temperature of 100.0) in the last 24 hours?	□Yes □No
Have you had a cough in the past 14 days?	□Yes □No
Have you had close contact (less than 6 ft) for a prolonged period (greater than 15 min) with a personal diagnosed with COVID?	□Yes □No
Do you have any shortness of breath?	□Yes □No
Have you lost your sense of smell or taste?	□Yes □No

XSignature_____Printed Name:_____ Relationship to Pt:_____Date_____

Name: _____DOB:_____Hand Dominance:☐R ☐L ☐Both

Diagnosis: _____

Referred for: ☐Occupational Therapy ☐Hand Therapy Evaluation ☐Orthosis Fabrication/Fitting ☐Ergonomics

Family Doctor:_____ Referring Provider: _____

Next Doctors visit with referring MD:____/____/___ IF accident, ☐HOME ☐AUTO ☐WORK ☐SPORTS ☐OTHER_____

Attorney: Name_____ Number:_____

Date of Onset/Injury:___/___/___ Date of Surgery:___/___/___ Type of Surgery: _____

What is the reason for your visit today:_____

Briefly describe the events leading to your visit at our office:_____

_____

What is your goal for therapy?_____

Treatments for this current complaint have included: PLEASE CHECK ALL THAT APPLY ☐No treatment received yet.

☐Physical Therapy☐Occupational Therapy ☐Pain management ☐)Surgical Intervention ☐Splints ☐Injections ☐_____

Diagnostic Tests for this current complaint have included: PLEASE CHECK ALL THAT APPLY

☐X-rays ☐Bone Scan ☐MRI ☐EMG ☐Nerve Conduction Study ☐CT scan ☐Bloodwork ☐_____

I have the following symptoms: PLEASE CHECK ALL THAT APPLY ☐Numbness ☐Tingling ☐Swelling ☐Weakenss

Occupation:_____Job Duties:_____

Current Work Status: ☐Retired ☐Full Time ☐PartTime ☐Regular Duty ☐Light Duty_____

Current living situation: Do you live alone: ☐YES☐NO. Do you have someone to help you if needed? ☐YES☐NO_____

Pacemaker: ☐YES ☐NO Pregnant: ☐YES☐NO Neurostimulator: ☐YES☐NO Hearing aid: ☐YES☐NO

Allergies: PLEASE CHECK ALL THAT APPLY ☐Medications ☐Adhesives ☐Latex ☐Seasonal ☐Food ☐Other:_____

Medication list (please submit)_____

PMH PLEASE CHECK ALL THAT APPLY:

☐skin problems	☐Drug/Alcohol Dependency	☐Eating Disorder
☐Heart trouble/heart attack/heart surgery	☐Immune Suppression	☐Chronic/recurrent infection
☐Thyroid problems	☐Eye Problems	☐Emotional/Psychological disorder
☐Diabetes ()Insulin Pump	☐Asthma	☐Cognitive Issues
☐Immune disorder/Lupus	☐Stroke/Paralysis	☐Hearing Loss/Hearing Aids
☐Tumor/Cancer	☐Neck/Back Injury	☐Loss of limb
☐HIV/AIDS	☐Depression or Anxiety	☐Seizures

☐Others:_____

Pain: **PRESENT**: 0 1 2 3 4 5 6 7 8 9 10 **BEST**: 0 1 2 3 4 5 6 7 8 9 10 **WORST:** 0 1 2 3 4 5 6 7 8 9 10

Pain is: ☐constant ☐intermittent, daily ☐Occasional, less than daily ☐Sporadic, less than weekly

What makes the pain better: _____ Does time of day affect your pain? ☐Yes☐No

What makes the pain worse:_____ Does pain wake you up from sleep? ☐Yes ☐No

Since pain started, it is ☐Getting worse ☐ Improving ☐Same Location of pain: _____

Describe the pain:CHECK ALL THAT APPLY: ☐dull ☐sharp ☐steady ☐throbbing ☐pulsing ☐aching ☐stabbing ☐stinging☐burning ☐shooting

☐other:_____

XSignature_____Printed Name:_____ Relationship to Pt:_____Date_____

ACTIVITIES OF DAILY LIVING QUESTIONNAIRE: Please check off the box next to each activity indicating how much help you need to complete the activity. If you can do the activity independently but it's painful please place a STAR * next to that activity too.

ACTIVITY	I can do this activity by myself without changing the way I do it.	I can do this activity by myself with a tool or I do it differently now.	I need a little help to do the activity. (Need 25% help)	I need a medium amount of help to do the activity. (Need 50% help)	I need a lot of help to do the activity. (Need 75% help)	I can't do the activity at all. (I need 100% help)
Pushing/pulling door						
Turning a key						
Reaching overhead						
Lifting heavy items						
Cutting food						
Driving						
Putting on a shirt						
Putting on pants						
Putting on socks						
Tying shoes						
Buttoning/ fastening						
Bathing upper body						
Bathing lower body						
Cooking						
Personal hygiene						
Deodorant						
Typing						
Writing						
Electronic portable devices						
Opening bottles						
Zippers						
Fastening bra						
Tying necktie						
Manipulating small items						
Turning knob						
Pushing self up from low surface						
	Independent	Modified Independent	Minimal Assistance	Moderate Assistance	Maximal Assistance	Dependent

XSignature_____Printed Name:_____ Relationship to Pt:_____Date_____

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
Open a tight or new jar	1	2	3	4	5
Do heavy household chores (washing walls or floor)	1	2	3	4	5
Wash your back	1	2	3	4	5
Use a knife to cut food	1	2	3	4	5
Recreational activities in which you take some force or impact through your arm, shoulder or hand (golf, hammering, tennis)	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
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	NONE	MILD	MODERATE	SEVERE	EXTREME
Arm, Shoulder or hand pain.	1	2	3	4	5
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
During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand (circle a number)	1	2	3	4	5

A quickDASH score may not be calculated if there is greater than 1 missing item.

Therapist to Score={[(sum of n responses)/n]-1} x 25, where n=the number of completed responses

XSignature_____Printed Name:_____ Relationship to Pt:_____Date_____