
# Patient Intake Form

Hands On Therapy

## Personal Information

Please note that this form is HIPAA compliant and is submitted through a secured website

**Name** *

First Name

Last Name

**Email**

example@example.com

**Hand Dominance**

**SS# (last 4 digits)** *

ex: 2355

**Please upload an image of your ID**

Browse Files

Uploading this will help us to speed up your check in process and decrease social contact

**Please upload an image of the front of your insurance card**

Browse Files

Uploading this will help us to speed up your check in process and decrease social contact

**Please upload an image of the back of your insurance card**

Browse Files

Uploading this will help us to speed up your check in process and decrease social contact

**Please upload an image of your secondary insurance card (if applicable)**

Browse Files

Uploading this will help us to speed up your check in process and decrease social contact

---

**Primary Care Physician**

First Name

Last Name

**Next appointment with referring MD**

mm-dd-yyyy

Date

---

**Work status**

- ◯ Retired
- ◯ Full Time
- ◯ Part Time
- ◯ Unable to work because of injury
- ◯ Not working at this time (regardless of injury)

**If currently working full or part time:**

**Occupation**

**Job duties**

Type here...

**If not currently working, when was your last time at work**

**Do you live alone?**

**Is someone there to help you if needed?**

**Modality Clearance Check any/all that apply:** *

- [ ] Pacemaker
- [ ] Neurostimulator (in bladder or spine)
- [ ] Hearing aid
- [ ] Diabetic/Insulin Pump
- [ ] Pregnant
- [ ] None

**Allergies Check any/all that apply:** *

- [ ] Medications
- [ ] Adhesives
- [ ] Latex
- [ ] Seasonal
- [ ] Food
- [ ] None
- [ ] Other

**List of Medication(s)** *

Please write "none" if this does not apply

+

**Past Medical History (PMH)** *

- [ ] Skin Problems
- [ ] Thyroid Problems
- [ ] Diabetes
- [ ] Tumor/Cancer
- [ ] Drug/Alcohol Dependency
- [ ] Eye Problems
- [ ] Stroke/Paralysis
- [ ] Heart Trouble/Attack/Surgery
- [ ] Diabetes
- [ ] Immune Disorder/Lupus
- [ ] HIV/AIDS
- [ ] Immune Suppression
- [ ] Asthma
- [ ] Neck/Back Injury

- [ ] Depression or Anxiety
- [ ] Eating Disorder
- [ ] Chronic/Recurrent Infection
- [ ] Emotional/Psychological/Mood Disorder
- [ ] Cognitive Issues
- [ ] Hearing Loss/Hearing Aids
- [ ] Loss of Limb
- [ ] Seizures
- [ ] None
- [ ] Other

**List past surgeries or major medical problems/illness**

+

**Have you been to Hands On Therapy before?**

- ( ) Yes
- ( ) No

## Current Condition

**Briefly explain the reason for your current visit, including the events leading to your visit** *

**Date of Onset/Injury** * mm-dd-yyyy

Date

**Treatment(s) you received for current complaint:** *

- [ ] Physical therapy
- [ ] Occupational therapy
- [ ] Pain management
- [ ] Surgical intervention
- [ ] Splint(s)
- [ ] Injection(s)
- [ ] No treatment
- [ ] Other

**Diagnostic tests you received for current complaint:** *

- [ ] X-ray
- [ ] MRI
- [ ] EMG
- [ ] Nerve Conduction Study
- [ ] CT scan
- [ ] Bloodwork
- [ ] None
- [ ] Other

---

**If surgery: Date**

mm-dd-yyyy

Date

**If surgery: Type**

Type here...

---

**If accident: Where did it occur?**

- ◯ Home
- ◯ Auto
- ◯ Work
- ◯ Other

**Attorney Name**

First Name Last Name

**Attorney Phone**

Area Code - Phone Number

---

**I have the following symptom(s):** *

- [ ] Numbness/Tingling
- [ ] Swelling

- [ ] Weakness
- [ ] Pain
- [ ] Hypersensitivity
- [ ] Decreased motion

**Goal(s) for therapy**

- [ ] Decrease numbness/tingling
- [ ] Decrease hypersensitivity
- [ ] Decrease swelling
- [ ] Decrease pain
- [ ] Increase sensation
- [ ] Increase strength
- [ ] Increase function
- [ ] Increase range of motion

**Select the 3 tasks that you have the most difficulty performing** *

- [ ] Getting dressed
- [ ] Lifting heavy items
- [ ] Performing household chores
- [ ] Cooking
- [ ] Opening jars/cans
- [ ] Manipulating small items
- [ ] Reaching overhead
- [ ] Other

---

**Since its started, is your condition:** *

**Rate your current level of pain (0=none; 10=hospital)** *

**Rate the LOWEST your pain has been in the past 7 days (0=none; 10=hospital)** *

**Rate the HIGHEST your pain has been in the past 7 days (0=none; 10=hospital)** *

**How often do you experience pain?** *

**Indicate the nature of your pain** *

- [ ] Dull
- [ ] Steady
- [ ] Pulsing
- [ ] Stabbing
- [ ] Burning
- [ ] Sharp
- [ ] Throbbing
- [ ] Aching
- [ ] Stinging
- [ ] Shooting
- [ ] Other

**Location of pain**

Type here...

**What makes your condition worse?**

**What makes your condition better?**

**Does time of day affect your pain?** *

- ◯ Level of pain not dependent upon time of day
- ◯ Pain worst at early morning
- ◯ Pain worst at mid day
- ◯ Pain worst at evening
- ◯ Pain worst throughout night
- ◯ Other

**Does pain wake you up at night?**

**Any additional information you would like us to know?**

Type here...

# QUICK DASH

Please rate your ability to do the following activities IN THE LAST WEEK

*

| | No Difficulty (1) | Mild Difficulty (2) | Moderate Difficulty (3) | Severe Difficulty (4) | Unable (5) |
|---|---|---|---|---|---|
| Open a tight/new jar | ○ | ○ | ○ | ○ | ○ |
| Do heavy household chores | ○ | ○ | ○ | ○ | ○ |
| Carry a shopping bag or briefcase | ○ | ○ | ○ | ○ | ○ |
| Wash back | ○ | ○ | ○ | ○ | ○ |
| Use a knife to cut food | ○ | ○ | ○ | ○ | ○ |
| Perform recreational activities in which you take some force/impact through your arm/shoulder/hand | ○ | ○ | ○ | ○ | ○ |

*

| | Not at All (1) | Slightly (2) | Moderately (3) | Quite a Bit (4) | Extremely (5) |
|---|---|---|---|---|---|
| To what extent has your arm/shoulder/hand problems interfered with your normal social activities with friends/family/neighbors/groups? | ○ | ○ | ○ | ○ | ○ |

*

| | Not Limited at All (1) | Slightly Limited (2) | Moderately Limited (3) | Very Limited (4) | Unable (5) |
|---|---|---|---|---|---|
| Were you limited in your work or other regular daily activities as a result of your arm/shoulder/hand problem | ○ | ○ | ○ | ○ | ○ |

**Please rate the severity of the following symptoms in the last week** *

| | None (1) | Mild (2) | Moderate (3) | Severe (4) | Extreme (5) |
|---|---|---|---|---|---|
| Arm, shoulder, or hand pain | ◯ | ◯ | ◯ | ◯ | ◯ |
| Tingling (pins and needles) in your arm, shoulder, or hand | ◯ | ◯ | ◯ | ◯ | ◯ |

*

| | No Difficulty (1) | Mild Difficulty (2) | Moderate Difficulty (3) | Severe Difficulty (4) | So Much Difficulty That I Cannot Sleep (5) |
|---|---|---|---|---|---|
| How much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand | ◯ | ◯ | ◯ | ◯ | ◯ |

## Appointment Reminders

**I prefer to receive appointment reminders by:** *

- ◯ Text
- ◯ Email

**If text: Phone**

Area Code - Phone Number

**If text: Cell phone carrier**

- ◯ Verizon
- ◯ AT&T
- ◯ Sprint
- ◯ Tmobile
- ◯ Other

**If text: I realize that carrier charges may apply**

- ◯ Yes

**If Email:**

example@example.com

## Emergency Contact

**Name** *

First Name Last Name

**Phone Number** *

Area Code - Phone Number

**Relation** *

## Authorization/Consent

**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.

**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

**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.Copays or fees for service including deductibles, are due and payable at the time of service. We accept cash, checks and credit cards. We have a touchless system for all our checkin procedures. We will keep your payment source (credit card/bank info) on file which will be used to pay any copays and 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 determined by your insurance benefit. 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. Copays and deductible and cancellation fees will be processed within 5 business days. Since the payment amount on the monthly statement may vary, I will receive emailed notification of the amount and date of the next charge prior to each transaction date. 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.

**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 your 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 for Photo/Video:** I grant permission to Hands on Therapy the rights of my image, in video or still, and of the likeness and sound of my voice as recorded on audio or video tape. I waive any right to royalties or other compensation arising or related to the use of my image or recording. I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the internet. If I do not agree with this statement, I will provide written disagreement to Hands on Therapy on my first visit.

**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.

**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.

**Name & signature of patient/legally responsible person** *

Clear

**If signed by someone other than pt, state relationship to pt and reason why patient is unable to sign**

**Date Signed** *

mm-dd-yyyy

Date