



Buzzards Bay Hand Therapy, LLC

119 Wareham Rd. Unit 107
Marion, MA 02738
(508) 748-3933
FAX: (508) 748-3944

Patient Information

Name: Last _____ First _____ MI _____ Date of Birth: _____
Mo. Day Yr.

Address: _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Sex: Male Female Status: Student Single Married

Employer _____ Occupation _____

Address _____ Phone: _____

City _____ State _____ Zip _____

General Information

Date of onset of problem _____ Surgery date _____ Last Dr's visit _____

Referring Doctor _____ Primary Care Physician _____

Ongoing/New Problem _____ Work Accident _____ Auto _____ Other _____

If Work Comp: Claim Number _____

Adjusters Name _____ Phone Number _____

Insurance Information

Primary Insurance Company _____ Policy/ID Number: _____

Address _____ PPO _____ HMO _____ Other _____

Phone Number _____

Who is responsible for the account?

Name: Last _____ First _____ Relationship to patient: _____

Address _____

City _____ State _____ Zip _____

Secondary Insurance Company (if applicable) _____

Policy/ID Number _____ Phone Number _____

Address: _____ PPO _____ HMO _____ Other _____

We will need a copy of your insurance cards. Please give us new copies if insurance changes.

Medical Information

Surgical History	Date	Medical History
<input type="checkbox"/> Joint Replacement	_____	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Shoulder Surgery	_____	<input type="checkbox"/> CVA/Stroke
<input type="checkbox"/> Knee Surgery	_____	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Neck Surgery	_____	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Back Surgery	_____	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Hand Surgery	_____	<input type="checkbox"/> Anxiety/Depression
<input type="checkbox"/> Heart Surgery	_____	<input type="checkbox"/> Cancer
<input type="checkbox"/> Abdominal Surgery	_____	<input type="checkbox"/> Asthma/Bronchitis/Emphysema
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Head Injury
_____	_____	<input type="checkbox"/> Arthritis
_____	_____	<input type="checkbox"/> Seizures
_____	_____	<input type="checkbox"/> Fractures
_____	_____	<input type="checkbox"/> Allergies/Drug Reactions _____
		<input type="checkbox"/> Other _____

Have you had Occupational or Physical Therapy within the last 12 (twelve) months? _____
If yes, state reason and dates:

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge **\$25.00** for missed appointments per each half-hour scheduled. We have a 24-hour answering service. We may have patients waiting for appointments on a cancellation list. Your phone call allows us to schedule them. This charge is not covered by or billed to your insurance. If due, please pay it at the front desk before your next appointment. *Your signature indicates that you understand our policy.*

ASSIGNMENT AND RELEASE

I authorize payments of benefits directly to **Buzzards Bay Hand Therapy** for services rendered. I also authorize release of my medical information that may be required in determination of such benefits.
 I understand that some services may require approval of my primary care physician for coverage and that if I do not obtain that approval, I am financially liable for the services.
 I understand that my insurance carrier may not cover some services and products and benefits obtained on my behalf. Deductibles and fees not paid by my insurance carrier will be my responsibility.
 This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that the **Buzzards Bay Hand Therapy** Privacy Policy is displayed in waiting areas and that a copy of this policy is available to all patients.

I authorize **Buzzards Bay Hand Therapy** to disclose my medical information on my home answering machine/voice mail Yes No

I authorize **Buzzards Bay Hand Therapy** to disclose my medical information to the person(s) listed herein:

Signature _____ **Date** _____

Signature of Guardian/Personal Representative _____ **Date** _____

Relationship to Patient _____