HAND TO HAND THERAPY CLINIC, LLC
WELCOME PATIENT INTAKE

Patient Information

Name Last_____ First _____ MI ____ Date_____
Current address_____ City _____ State _____ Zip_____
LOCAL Phone H_____W _____Cell_____
E-Mail Address_____Social Security_____
☐ Male ☐ Female ☐ Student ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Date of Birth: month _____ day _____ year _____ Drivers License _____
Permanent Address_____
City _____ State,_____ Zip _____
Employer_____ Occupation_____
Employer address_____ City _____ State ____ Zip _____
Employer Phone Number :

General information

Referring Doctor_____ Family Doctor_____
Description of Problem_____ Date of Onset _____
Was there an Accident? Auto_____ Work _____Other_____ Claim Number _____
Adjuster _____ Adjusters Phone Number _____
Have you had Surgery? Y___N___ If yes when? _____ Surgeon_____

Responsible Party

Who is responsible for the account?
Name Last_____ First_____ MI ___ Relationship to Patient_____
Address _____ City _____ State _____ Zip_____
☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Date of Birth: month _____ day _____ year _____ DL# _____SS#_____
Employer _____ Work Phone _____ Home phone_____
Insurance Co_____ Policy # _____
Insurance Phone_____ Is There Secondary Insurance? Y_____N_____
In Case of Emergency:
Name of friend or relative**:**_____Relationship**:**_____Phone #_____

Medical Release of Information

I authorize the release of any medical information necessary to process this claim.
Signature _____ **Date** _____

Assignment of Benefits/ Consent to Treatment: I hereby assign payment directly to **Hand to Hand Therapy Clinic, LLC,** who represents this clinic to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. I do hereby consent to such treatment by authorized personnel of Hand to Hand Therapy Clinic as may be dictated by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Signature _____ **Date** _____

Unaccompanied Minors

The parents (or guardians) are responsible for full payment at the initial visit. Subsequent charges may be billed to the insurance company, but co-payments, deductibles, and non-covered amounts must accompany the minor at each visit. ☐

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge $40 for missed appointments. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions of concerns. ☐