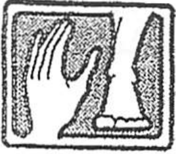

HUMBOLDT HAND & FOOT THERAPY, INC.

1587 Myrtle Avenue, Eureka, CA 95501-1453
Phone (707) 441-1931 Fax (707) 441-1940
humhandfoot@sbcglobal.net

PATIENT REGISTRATION FORM

Last Name		First Name		Middle Initial
Mailing Address		City	State	Zip
Residence Phone	Work Phone	Cell Phone		Sex
Date of Birth	Patient's SS#	Who is Responsible for Payment?		
Employer		Occupation	Are You Currently Working? Y_____ N_____ Were You Injured at Work? Y_____ N_____	
Employer Address			Employer Phone	
Date of Injury		Referring Physician		
Email		Emergency Contact Name / Relation		Phone

RESPONSIBLE PARTY **Please Complete for Responsible Party / Parent of Minor:**

Last Name	First Name			MI
Mailing Address	City		State	Zip
Residence Phone	Work Phone	Cell Phone		
Social Security #	Date of Birth			
Employed By	Address	City	State	Zip

MEDICAL RELEASE INFORMATION **Please complete for Responsible Party/Parent of Minor**

_____ **Initial** - I authorize holder of medical information about me to release to my insurance company, it's intermediaries, or any medical provider, information needed for this, a related claim, or further medical referral. I permit a copy of this authorization to be used in place of the original and request payment of insurance directly to HHFT.

_____ **Initial** - I authorize HHFT, to photograph my injured extremity for medical file purpose.

_____ **Initial** - I hereby authorize HHFT, to perform treatment as prescribed by my physician.

______________________________ ________________ ____________

Patient Signature **Date** **Office use**

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HIPAA

Protected Health Information (PHI) is very important. Basically, it is any element of health information that identifies a patient or provides a reasonable basis for identifying a patient.

Patients have new rights:

- Right to request privacy protection for protected health information (PHI)
- Right to access PHI
- Right to request an accounting of disclosures of PHI
- Right to a copy of the provider's Notice of Privacy Practices
- Patients will be asked to sign a release of information if information is requested outside of practice
- All patient information will be kept confidential within the practice

We at Humboldt Hand and Foot Therapy are dedicated to complying with all rules and regulations regarding HIPAA compliance.

I am aware a copy of the Providers Notice of Privacy Practices is available to me and is also posted in the office lobby.

______________________ Patient/Parent/Guardian Signature ______________ Date __________ Office Use Only

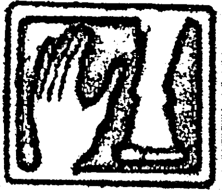
MEDICARE PATIENTS

Please let us know if you are under the care of Home Health in any way before your visit.

Medicare requires that patients receiving Physical/Occupational Therapy must have a current referral that is updated after the first 30 days of treatment and every 30 days thereafter by the current referring physician.

I acknowledge that I have read this Medicare policy by my signature below.

______________________ Patient/Parent/Guardian Signature ______________ Date __________ Office Use Only



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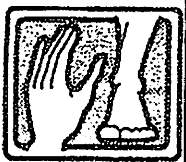

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PATIENT INTAKE---MEDICAL HISTORY

Do you have, or have you had in the past any of the following?

	Yes	No	
***	____	____	**Are you currently being treated for cancer? *** **
	____	____	Allergies -- Specify________________________
	____	____	Diabetes
	____	____	Loss of Balance/Falling
	____	____	Adhesive Allergy (tape or band-aids)
	____	____	Women patients: Are you or could you be pregnant?
	____	____	Pacemaker/Defibrillator
	____	____	All Patients: Are you presently taking any medications? If yes, please

list all medication names, dosages and frequency taken on the other side of this form. If you do not take any medication please write NONE and sign your name.

FINANCIAL POLICY

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our relationship. We are pleased to discuss our professional fees with you at any time. If you have any questions regarding fees, our financial billing policy, or your financial responsibility, please do not hesitate to ask.

- If a patient is a minor, his/her parent or guardian is responsible for payment(s)
- We are glad to bill your insurance for you.
- Insurance is a contract between you and your insurance company. We will not become involved in disputes, between you and your insurance company regarding deductibles, copayments, coverage, secondary, usual and customary charges etc., other than to supply factual information as necessary.
- Please note that co-pays are due at the time of service. Thank you

Monthly Payment Policy

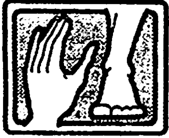
- Patients who are responsible for deductibles, copayments, and non-covered services or materials will be required to be paid in full monthly. If there is extenuating circumstances, then you need to contact the billing office and discuss your circumstances so special payment arrangements can be made.

Missed Appointments

- Unless appointments are cancelled 24 hours in advance, our policy is to charge patient for missed appointments at the rate of $50.00 per visit.

______________________________ ________________ ________________

Patient's Signature **Date** **Witness**



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MEDICATION LIST

Your insurance requires that we obtain this information.

Please list all medications, either prescription or over the counter (supplements, vitamins, herbals) Please provide the name, dosage and how often it is taken.

<u>This must be filled out and brought in on your first visit.</u>

Patient________________________________

1.________________________________ 2. ________________________________

3.________________________________ 4. ________________________________

5.________________________________ 6. ________________________________

7.________________________________ 8. ________________________________

9.________________________________ 10.________________________________

11.________________________________ 12.________________________________

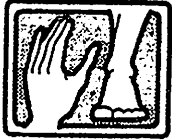
13.________________________________ 14.________________________________

15. ________________________________ 16.________________________________

If more space is needed please attach another sheet of paper.

Height:______________ Weight________________

Are you currently a smoker? YES ___ NO___ If you quit, when________________



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3.______________________________ 4. ______________________________

5.______________________________ 6. ______________________________

7.______________________________ 8. ______________________________

9.______________________________ 10.______________________________

11.______________________________ 12.______________________________

13.______________________________ 14.______________________________

15. ______________________________ 16.______________________________

If more space is needed please attach another sheet of paper.

Height:_____________ Weight_______________

Are you currently a smoker? YES ___ NO___ If you quit, when_______________