PATIENT REGISTRATION

Patient Name:____
(Last) (First) (M.I.)

Address:____

City:____________________________________State:___________________Zip:___________________

Home Phone:________________Work Phone:________________Cell Phone:_____________________

Birth Date:______________Marital Status:_______Sex:____F____M Soc. Sec. #:________________

Patient's Parent or Spouse:___________________________________ Soc. Sec. #:________________

Patient's Occupation:_________________________________Employer:__________________________

Referring Doctor:__________________________Primary Care Physician:_________________________

Date of Injury:__________________________Cause:____

Date of Surgery:________________________Cause:____

Was this an ON THE JOB INJURY?____Yes____No If yes, Claim #:___________________________

Was this and AUTO ACCIDENT?____Yes____No If yes, Claim #:_____________________________

Is this a THIRD PARTY claim?____Yes____No If yes, we do not accept third party claims

Insurance Company:_______________________Address:_______________________________________

Adjustor's Name:__________________________Phone #:_______________________________________

Primary Insurance Carrier:__________________________Subscriber Name:_______________________

Subscriber ID #:________________________Group #:____________________Birth Date:___________

Subscriber Employer:____

Patient's Relationship to Insured:______Self______Spouse______Dependent______Other

Secondary Insurance Carrier:________________________Subscriber Name:_______________________

Subscriber ID #:________________________Group #:____________________Birth Date:___________

Subscriber Employer:____

Patient's Relationship to Insured:______Self______Spouse______Dependent______Other

In Case of Emergency, Call:_______________________Relation:___________Phone:_______________

<u>ASSIGNMENT AND RELEASE:</u> I hereby authorize my insurance benefits to be paid directly to Valley Handworks, Inc., and I am financially responsible for any and all services including non-covered services. I also authorize the release of any information required to process insurance.

Signed:____Date:____________________

Office Payment Policy

Patient: ____

We want to thank you for choosing Valley Handworks for your hand therapy. Though our primary concern is your health care needs, we also need you to be aware of our office policies.

- Patients are required by law to complete an updated patient information sheet once every 365 days. For identification purposes a copy of a photo ID will be required.
- Patients are required to give updated information as it changes, i.e.: address, phone, insurance, or other pertinent information.
- All co pays are due at the time of service. A $10 billing fee will be charged for every unpaid co pay. No appointments will be allowed until past co pays are paid.
- Cash patients are expected to pay at the time of service, otherwise the appointment will be rescheduled. New patients are to pay at the time of service in full. Established patient's cost will vary depending on the level of service.
- Accounts in past due status will be required to set up a payment plan with our billing service prior to future appointments.
- Accounts 90 days past due will be referred to our collection agency and future appointments will not be allowed.
- Auto accidents: Your motor vehicle insurance is primary. We will need you claim number and claims mailing address. We do not bill third party insurance. We are a "Fee for Service" caregiver and cannot hold accounts pending litigation. We expect regular monthly payments from you or your insurance.
- On the job injuries: If your claim is closed or denied you will be responsible for all unpaid charges. (We will then bill your personal health insurance if requested)
- Items or services denied for non-covered benefits or non-covered services by your insurance are the liability of the patient.
- Patients will be responsible for no show fees when they do not cancel prior to their appointment.
- We accept cash, checks, and credit cards.

I have read, understand, and accept the Valley Handworks Office Payment Policy. In accordance with HIPAA regulations I have received a copy of the Notice of Privacy Practices.

Signature: ____Date: ________________

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Who Will Follow This Notice
This notice describes information about privacy practices followed by our employees, staff, and other office personnel. Please review it carefully.

Your Health Information
This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.
We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How We May Use and Disclose Health Information About You
For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.
For Example:

- Your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment.
- The doctor may use your medical history to decide what is best for you.
- The doctor may also tell another doctor about your condition so the doctor can help determine the most appropriate care for you.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, and insurance company, or a third party.
For Example:

- We may need to give your health plan information or tell them about a service you received here so your health plan will pay us or reimburse you for the service.
- We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure you and out other patients receive quality care.
For Example:

- We may use your health information to evaluate the performance of our staff in caring for you.
- We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.
- We may contact you as a reminder that you have an appointment or medical care at this office.
- We may tell you about or recommend possible treatment options or alternatives that me be of interest to you.
- We may tell you about health-related products or services that may be of interest to you.

Special Situations
We may use or disclose health information about you without your permission for the following purposes, subjects to all applicable legal requirements and limitations.

- To avoid a serious threat to health and safety.
- As required by law, such as for law enforcement or in response to a subpoena or court order.
- Research approved by an Institutional Review Board.
- Military, Veterans, National Security, and Intelligence.
- Worker's Compensation.
- Public health risks.
- Lawsuits and disputes.
- Law enforcement.
- Coroners, Medical Examiners, and Funeral Directors.

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(253) 639-3336

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

I acknowledge a receipt of a copy of the Notice of Privacy Practices of VALLEY HANDWORKS.

____

Patient or legally authorized individual signature Date Time

Please include the names of persons with whom we are allowed to discuss your billing information and/or condition.

____________________________________ ____________________________________

Name Relationship

____________________________________ ____________________________________

Name Relationship

____________________________________ ____________________________________

Name Relationship

I authorize Valley Handworks, Inc., to discuss my billing information and/or condition with above name(s)/person(s).

____ _______________________

Patient or legally authorized individual signature Date

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Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

May we leave a detailed message on your answering device if we are unable to reach you in person?

______YES ______NO

REQUEST SIGNATURE FROM EVERY PATIENT

This form will be retained in your medical record.