Central Coast Hand Rehab

Patient Information

Last Name	Middle Initial	First Name	Date of Birth	Sex	Age

Have you been treated at this office before?	If yes when?

Address	City	State	Zip

Home Phone #	Work Phone #	Cell Phone #	Would like to receive Text reminders

Email Address	

Responsible Party	Relationship	Date of Birth

Responsible Party's Address

Employer	Occupation/Student

Emergency Contact	Phone Number

Name of spouse

Who referred you to this office?

Reason for referral	Date of injury	Date of surgery

Which side is injured?	Circle one: Right Left Bilateral

Is this treatment for an accident ___ yes ___no?
How did accident happen? _____
Where did accident occur? _____

Medical History

Diabetes	Yes__ No__	Metal Implants	Yes__ No__
Headaches	Yes__ No__	Kidney Problems	Yes__ No__
Hernia	Yes__ No__	Nervous disorders	Yes__ No__
Seizures	Yes__ No__	Heart Attack/Disease	Yes__ No__
Pace Maker	Yes__ No__	High Blood Pressure	Yes__ No__
Allergies	Yes__ No__	Previous Surgeries	Yes__ No__

List all current medications: _____

_____

Other pertinent medical history: _____

_____

List type and date (Mo/Yr.) of pertinent surgeries: _____

_____

List allergies: _____

_____

· Abuse Suspicion Index

Questions 1-5 asked of patient.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
Yes
No
Did not answer

2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?
Yes
No
Did not answer

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
Yes
No
Did not answer

4. Has anyone tried to force you to sign papers or to use your money against your will?
Yes
No
Did not answer

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physicaliy?
Yes
No
Did not answer

Instructions:

Choose the best answer for have you have felt over the past week:

1. Are you basically satisfied with your life? Yes **No**

2. Have you dropped many of your activities and interests? **Yes** No

3. Do you feel that your life is empty? **Yes** No

4. Do you often get bored? **Yes** No

5. Are you in good spirits most of the time? Yes **No**

6. Are you afraid that something bad is going to happen to you? **Yes** No

7. Do you feel happy most of the time? Yes **No**

8. Do you often feel helpless? **Yes** No

9. Do you prefer to stay at home, rather than going out and doing new things? **Yes** No

10. Do you feel you have more problems with memory than most? **Yes** No

11. Do you think it is wonderful to be alive now? Yes **No**

12. Do you feel pretty worthless the way you are now? **Yes** No

13. Do you feel full of energy? Yes **No**

14. Do you feel that your situation is hopeless? **Yes** No

15. Do you think that most people are better off than you are? **Yes** No

Consent Telehealth Consultation

Central Coast Hand Rehab Center

805-542-0830 cchrhand@gmail.com

I understand that my Occupational Therapist/ Hand Therapist recommends engaging in telehealth services with me to provide treatment.

I understand this is out of necessity and an abundance of caution and has originated due to coronavirus (covid-19) pandemic. This will continue until such time that we are able to meet in person, or could continue, depending on the particular circumstance.

I understand that telehealth treatment has potential benefits including, but not limited to, easier access to care.

I understand that telehealth has been found to be effective in treating a wide range of disorders, and there are potential benefits including but not limited to easier access to care. I understand however there is no guarantee that all treatment of all patients will be effective.

I understand that it is my obligation to notify my OTR/CHT of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify my therapist of the location change.

I understand that it is my obligation to notify my OTR/CHT of any other persons in the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my OTR/CHT at the outset of each session and am aware that confidential information may be discussed.

I understand that it is my obligation to ensure that any virtual assistant artificial intelligence devices, including but not limited to Alexa or Echo, will be disabled or will not be in the location where information can be heard.

I agree that I will not record either through audio or video any of the session, unless I notify my OTR/CHT and this is agreed upon.

I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technological issues with software, hardware, and internet connection which may result in interruption.

I understand that my OTR/CHT is not responsible for any technological problems of which my OTR/CHT has no control over. I further understand that my OTR/CHT does not guarantee that technology will be available or work as expected.

I Understand that I am responsible for information security on my device, including but not limited to, computer, tablet or phone and in my own location.

I understand that my OTR/CHT or I (or if applicable, my guardian or conservator), can discontinue the telehealth consult/ visit if it is determined by either me or my OTR/CHT that the video conferencing connections to protections are not adequate for the situation.

I have had a conversation with my OTR/CHT, during which time I have had the opportunity to ask questions concerning services via telehealth. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me.

Zoom is the technology service we will use to conduct telehealth video conferencing appointments. Prior to each session, I will receive an email link to enter the “waiting room” until the session begins. There are no passwords or log in required.

By Signing this document, I acknowledge:

Central Coast Hand Rehab is NOT an emergency service. In the event of an emergency, I will use a phone to call 9-1-1 and/or another appropriate emergency contact.

1. I recognize my OTR/CHT may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to a risk to self/others or my OTR/CHT is concerned the immediate medical attention is needed.

2. Though my OTR/CHT and I may be in virtual contact through telehealth services, neither Zoom or my OTR/CHT provides any medical or emergency or urgent healthcare services or advice. I understand should medical services be required; I will contact my physician. If emergency services are needed, in understand I should call 9-1-1.

3. Zoom facilities video conferencing and this technology platform is not, itself, a source of healthcare, medical advice, or care.

4. I understand that the same fee rates apply for telehealth as apply for in-person treatment. Some insurers are waiving co-pays during this time. It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable co-pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions. I understand that if my insurance, HMO third-party payor, or other managed care provider, do not cover the telehealth sessions, I will be solely responsible for the entire fee of the session.

5. During these times of the impact of Coronavirus (Covid-19) my OTR/CHT may not have access to all of my medical/treatment records. My OTR/CHT has made reasonable efforts to obtain records, but I understand and agree this may not be reasonably possible.

6. To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.

7. I understand that either I or my OTR/CHT can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me. I understand there may be no other treatment alternative available.

I have read and understand the information provided above regarding telehealth, have discussed it with my OTR/CHT, and I hereby give informed consent to use of telehealth.

_____
Signature of patient (or guardian/conservator)

_____
Printed name

_____
Date

This questionnaire asks about your symptoms as well as your ability to perform certain activities.
Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Therapist Use Only

Comorbidities:
- ☐Cancer
- ☐Diabetes
- ☐Heart Condition
- ☐High Blood Pressure
- ☐Multiple Treatment Areas
- ☐Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI)
- ☐Obesity
- ☐Surgery for this Problem
- ☐Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)

ICD Code: _____

Consent to Treat Form

The patient authorizes the Occupational Therapist to examine and treat the condition as he/she deems appropriate through the use of occupational therapy measures, and the patient gives the authorization for these procedures to be performed.

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Occupational Therapist. The patient will not hold the Occupational Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures.

The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or consent of his /her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient shall be advised if Central Coast Hand Rehab Center, proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

After reading the above (or having it read to me), I hereby consent to receiving occupational therapy at Central Coast Hand Rehab Center to begin on this date and terminating when determined by myself, my physician or my Occupational Therapist.

I have read (or have had read to me) the above information and understand the content.

Patient/Guardian Signature _____ Date_____

Witness Signature _____ Date_____

Please list an emergency contact, either inside or outside of the home:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

CENTRAL COAST HAND REHAB - FINANCIAL POLICY / RECORDS RELEASE

This office cannot guarantee payment by said insurance company. In order to receive benefits, the member must be covered at the time of service. The benefits information is not all-inclusive. It is limited to some coverage highlights. Other terms and limitations may apply even though such provisions are not indicated to this office. All claims are subject to medical review according to the information submitted by the provider of the service and are subject to benefit agreements to determine the appropriate payment amounts and any limitations or exclusions. The deductible/accumulator information for your account is accurate at the time it is received. We cannot be responsible for any authorizations you make based on this information since additional claims or changes may have been filed and may not be reflected in the amounts received by this office at the time of request.

Payment for services is due upon receipt of monthly statements. As a service, we will bill your insurance if you provide all necessary information. If payment is not received from your insurance within sixty days of billing, you become responsible for payment of delinquent charges. Charges not covered by the insurance carrier are the patient's responsibility. Treatment is by appointment only. Failure to give twenty-four-hour notice can result in a $25 charge to the patient. This charge cannot be billed to the insurance company. **Initial _____**

MEDICARE PATIENTS ONLY:
The Current Medicare reimbursement limit for physical and occupational therapy services provided at an independent outpatient office is based on medical necessity after initial $100. Durable medical equipment such as splints or other therapy supplies may not be covered. These items are often necessary for the maximum therapy benefit and will be billed directly. I understand that I will be responsible for charges beyond medical necessity and for all durable medical equipment.

PLEASE INITIAL _____

Private insurance:
As a service to you our office receives verbal confirmation of your coverage. Please note your services at Central Coast Hand Rehab are billed under the physical rehab services of **Occupational Therapy**. Some plans bundle other outpatient services including chiropractic, physical therapy, occupational therapy, speech therapy, and or respiratory therapy.
Often the baseline number of visits can be extended if there is medical necessity and the member requests additional service. Often pre-authorization is required. **Initial _____**

If you have specific questions regarding the coverage or status of your plan please contact your insurance provider and/or your human resource office.

- I authorize release of information regarding my treatment to my insurance company.
- I assign insurance benefits for my treatment directly to Central Coast Hand Rehab.
- I hereby grant my permission to release information to Central Coast Hand Rehab as contained in my medical records as may be deemed necessary.

X_____ _____
Signature **Date**

Central Coast Hand Rehab

Patient:_____

I have received Central Coast Hand Rehab's Notice of Information and Privacy Practices,

Signature: _____
(Patient or Authorized Representative signature)

Date:_____

Relationship to patient:_____
(Applicable only if Authorized Representative signed for patient)

Central Coast Hand Rehab representative witness signature: _____

Date:_____

Central Coast Hand Rehab (CCHR)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CARE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your health record/information:

Each time you visit a hospital, physician, or each time a health care professional visits your home a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to you care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your health information rights:

Unless otherwise required by law your health record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to:

. Request in writing a restriction on certain uses and disclosures of your information. CCHR is not required to agree to comply with your requested restriction.

. Request in writing amendments to your health record, either clinical or demographic. Inspect and request in writing a copy of your health record

. Obtain an accounting of disclosures of your health information

. Request communications of your health information by alternative means or at alternative locations. Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our responsibilities:

Central Coast Hand Rehab is required to maintain the privacy of your health information. In addition, we will: Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you and will abide by the terms of this notice:

. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

. Any new notices will be on file at our office. We reserve the right to change our practices and to make the new provision effective for all protected health information we maintain. Should our information practices change, we will have notices at our office available for you.

For more information or to report a problem:

If you have questions and would like additional information, you may contact our office at (805) 542-0830. If you believe your privacy rights have been violated, you can also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

We will use your health information for treatment. Information obtained by the assessment professional will be recorded in your record and used to determine the course of treatment that should work best for you. By way of example, members of your healthcare team will then record the actions they took, their observations and education provided. We will also provide other practitioners involved with your care with copies of various reports that should assist them in treating you as well as enabling your physician to provide orders for your home care.

We will use your health information for payment. Your information will be utilized to obtain payment for services provided. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, services provided and supplies used. Outside collection agencies may also be utilized.

We will use your health information for regular healthcare operations. We may use and disclose health information in order to facilitate operations and as necessary to provide quality care to all patients. Examples include:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs. Protocol development, case management and care coordination. Employee performance and evaluation
- Training programs including those in which students, trainees or practitioners in health care learn under Supervision.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development Patient satisfaction surveys
- In coordination of emergency and disaster planning and implementation

For treatment alternatives: We may use and disclose your health information to tell you about **or** recommend possible treatment options or alternatives that may interest you.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples may include: therapy services, laboratory tests, supply distribution, and audit services. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however we require the Business Associate to appropriately safeguard your information.

Communication with *family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friends or any other person you identify, health information relevant to that person's involvement your care or payment related to your care.

Research: We may disclose information to researchers when a review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.

Marketing: We may contact you to provide information about your treatment alternatives or other health Related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): As required by law we may disclose to the **FDA** health information relative to adverse events with respect to food, supplements, products and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Privacy Practices availability: This notice will be prominently posted in the office. Patient will be provided a hard copy and the notice will be maintained at our office.

Authorization to use or disclose health information: Other than stated in this document, CCHR will not disclose your health information without your written authorization. If you or your representative authorizes CCHR to use or disclose your health information, you may revoke such authorization in writing at any time.

NOTICE OF INFORMATION & PRIVACY PRACTICE