

**WELCOME TO OUR CLINIC!**

**COVENANT HAND THERAPY, PC**

Please take a few minutes to answer the following questions so we can better assist you with your health care and insurance needs.

PATIENT'S NAME \_\_\_\_\_ PATIENT'S DATE OF BIRTH \_\_\_\_\_

PRIMARY INSURED PERSON \_\_\_\_\_ & INSURANCE ID# \_\_\_\_\_

& DOB \_\_\_\_\_ & EMPLOYER \_\_\_\_\_ & RELATIONSHIP TO PATIENT \_\_\_\_\_

INSURANCE CO. NAME \_\_\_\_\_ INS. CO. PHONE NUMBER \_\_\_\_\_

PLAN GROUP# \_\_\_\_\_ PLAN EFFECTIVE DATE \_\_\_\_\_ Check one: HMO POS PPO I WC

If HMO or POS: Primary Care Physician (PCP) Name \_\_\_\_\_ Phone \_\_\_\_\_

PCP Referral Required? Yes No If yes, insurance referral obtained? Yes No

If Workers' Compensation: Work Comp Adjuster \_\_\_\_\_ Phone \_\_\_\_\_

Referring/Prescribing Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Patient's Diagnosis: \_\_\_\_\_

*This Benefit Verification form is only a potential explanation of coverage obtained from the patient's insurance company & is not a guarantee of coverage, eligibility or payment. If the information provided by the insurance company is not accurate or the insurance company changes its coverage, the patient will be responsible for payment for services.*

*Patient Authorization, Release and Signature: I do not hold CHT &/or its affiliates responsible for any incorrect or omitted information, or for any changes in my future coverage. I also agree that I am responsible for the contract between myself & my insurance company.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**CHT staff use:**

**Occupational & Physical THERAPIES, office setting** ..... Pre-cert/auth? Yes No Phone \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Portion Met to Date \$ \_\_\_\_\_

\_\_\_\_\_ % Covered with Co-Pay Amount of \_\_\_\_\_ % or \$ \_\_\_\_\_ /visit

Out of Pocket \$ \_\_\_\_\_ Portion Met to Date \$ \_\_\_\_\_

OT dollar limit \$ \_\_\_\_\_ yr OT visit limit \_\_\_\_\_ Procedures not covered? \_\_\_\_\_

PT dollar limit \$ \_\_\_\_\_ yr PT visit limit \_\_\_\_\_ Procedures not covered? \_\_\_\_\_

Claim Requirements \_\_\_\_\_

PRE-AUTH OR REFERRAL # \_\_\_\_\_ EXPIRATION \_\_\_\_\_ Ins. Contact Name \_\_\_\_\_

**Durable Medical Equipment / hand & foot orthotics** ..... Pre-cert/auth? Yes No Phone \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Portion Met to Date \$ \_\_\_\_\_

\_\_\_\_\_ % Covered with Co-Pay Amount of \_\_\_\_\_ % or \$ \_\_\_\_\_ /visit

Out of Pocket \$ \_\_\_\_\_ Portion Met to Date \$ \_\_\_\_\_

Dollar limit for DME \$ \_\_\_\_\_ yr. **Compression Garments?** A6504 A6531 A6549 L8010 Yes No

Claim Requirements \_\_\_\_\_

PRE-AUTH OR REFERRAL # \_\_\_\_\_ EXPIRATION \_\_\_\_\_ Ins. Contact Name \_\_\_\_\_

NOTES \_\_\_\_\_ CLAIMS ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Benefits Verified by \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

# COVENANT HAND THERAPY, PC

Patient Name: \_\_\_\_\_

## Patient's Rights and Responsibilities

**The patient has the right** • to considerate and respectful service. • to obtain service without regard to race, creed, national origin, sex, age, disability diagnosis or religious affiliation. • (subject to applicable law) to confidentiality of all information pertaining to his/her service. [Individuals or organizations not involved in the patient's care may not have access to the information without the patient's written consent.] • to make informed decisions about his/her care. • to reasonable continuity of care and service. • to voice grievances without fear of termination of service or other reprisal in the service process.

**The patient is responsible** • for notifying CHT of any CHT DME equipment failure or damage. • for any CHT equipment that is lost or stolen while in their possession for notifying CHT of such loss. • for notifying CHT of any changes to their address or telephone. • for notifying CHT of any changes concerning their physician. • for notifying CHT of discontinuance of use of issued CHT equipment. • for any equipment rental and sale charges which the patient's insurance company does not pay, except where contrary to federal or state law.

## HIPAA Privacy Policy Effective Date: April 14, 2003

I understand that CHT is in HIPAA compliance regarding maintaining the highest degree of confidentiality of my personal and medical records information. A copy of the HIPAA Privacy Policy has been made available to me.

## Assignment of Benefits and Payment Guarantee

I authorize insurance payment directly to CHT for services. This is a direct assignment of my rights and benefits under this insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original.

As the ultimate responsible party, I agree to pay CHT for the services provided to me. If any law (such as workers compensation) or insurance contract prohibits payment for these services, I will cooperate and assist CHT in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatment unless agreed to in writing by myself and a CHT representative.

*If I am a Medicare patient, then I, the above named patient and Medicare beneficiary, with Medicare number \_\_\_\_\_ and Medigap or supplement insurance policy number \_\_\_\_\_, request that payment of authorized Medicare and Medigap or supplemental benefits be made either to me or on my behalf to CHT for any services furnished me by CHT. This authorization applies to all occasions of services until it is revoked.*

**Effective October 12, 2009**

**If you are unable to keep a scheduled appointment,  
please call CHT 24 hours prior to your scheduled appointment time.  
Otherwise, there will be a \$25.00 charge for missed appointments or late cancellations.**

**All patients:**

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Gender:  Male  Female Email \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Marital Status:  Single  Married  Widow(er)  
 Were you referred to us because of an Accident?  Auto  Work  Other  No  
 Injury Date and Details \_\_\_\_\_  
 Employer Name and Address \_\_\_\_\_  
 In case of Emergency, contact \_\_\_\_\_ phone number \_\_\_\_\_

Do you now have -- or have you ever had -- any of the following?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		Diabetes			Open Wounds related to current condition			Thyroid Problems
		Arthritis			Current Infection(s)			CVA / Stroke
		High Blood Pressure			Hypersensitivity to Heat or Cold			Previous Fracture
		Heart Disease			Allergies and/or Asthma			Osteoporosis
		Heart Attack			Hernia			Depression
		Pacemaker or Surgical Implant			Presently Pregnant			Anxiety
		Vascular Disease			Seizures			Substance Abuse
		Headaches / Migraines			Metal in Body			Previous surgeries
		Kidney Problems			Cancer / Tumor			Other

If you answered "yes" on any of the above, please explain and give approximate date(s):

Have you received any Occupational Therapy, Physical Therapy, Speech Therapy, or Chiropractic treatment during this current insurance plan year?  No  Yes -- if yes, how much?

**Are you NOW or WITHIN the LAST 60 DAYS receiving home-health care OR care at an out-patient hospital facility or nursing home facility?**  No  Yes  
**If yes, please give name and address of other provider:**

Are you presently taking any medications?  No  Yes. If yes, please list medications:

The information above is correct to the best of my knowledge.  
 Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

