Initial Evaluation Form

Date: ___ / ___ / ___

Name: _____ **Dominant Hand** (Circle) Right Left
Referring Doctor: _____ **Injured hand/arm** (Circle) Right Left
Primary Care Physician: _____ **Can we send report to them** (Circle) Yes No

Date of Injury: ____ / ____ /____ **Date of Surgery if applicable: ___ /___ /____**

Work Status (Circle): Full duty Light duty Retired Off work due to injury Other: _____

Workers Comp Patients: Occupation & Job duties: _____
_____

How did you injure your hand, elbow or shoulder? _____
_____

What problems are you having as a result of your referred diagnosis? (Check all that apply)
( ) Stiffness ( ) Weakness ( ) Pain at best ___ and at worst ___ with 0 = no pain and 10 = severe pain
( ) Numbness ( ) Unable to do grip tasks ( ) Unable to raise arm for activities
( ) The doctor said I cannot use my arm yet
( ) Other: _____

What are your goals of therapy?
( ) Increase motion ( ) Decrease pain ( ) Increase strength ( ) Normal hand/arm use
( ) My immediate goal is to protect hand/arm from re-injury with a custom orthotic/splint as my doctor ordered
( ) Other: _____

Are you taking any pain medication(s): ( ) Yes Name(s) of Medicine: _____ ( ) No

Do you have any medical conditions that would affect your ability to participate in therapy?
( ) Yes Conditions that I need to know about: _____
( ) No

Have you received recent home healthcare or had previous therapy for this condition elsewhere?( ) Yes ( ) No

ATTENTION ALL HMO PATIENTS!

In order to provide therapy we need authorization from your primary physician prior to treatment. If we cannot get your doctor to provide us with therapy authorization you will be responsible for all charges incurred.

THERAPY ATTENDANCE

We have the right to discharge your therapy at any time should you be unable to attend therapy as your doctor ordered. Optimal therapy results require regular therapy attendance and home exercise compliance. Your doctor will be notified of poor therapy attendance and will be faxed a copy of your discharge note.

Shoulder Elbow & Hand Therapy Specialist

First and Last Name_____ Middle Initial _____
DOB____/____/_____ Social_____
Sex (Circle) M F Marital Status (Circle) S M D W
Address _____
City_____ State _____ Zip Code _____
E-Mail Address _____
Home Phone _____ Cell Phone _____

How did this injury happen? (Circle) Auto Work Other
Nature of accident _____

Emergency Contact _____Phone Number_____

Responsible Party_____ DOB____/____/_____
Phone Number_____

Primary Insurance_____ Employer_____
ID#_____ Group#_____
Insured Name_____ Insured DOB_____/_____/_____
Insured Social_____ Case#_____
Adjuster_____ Phone#_____

Secondary Insurance_____
ID#_____ Group#_____
Insured Name_____ Insured DOB_____/_____/_____
Insured Social_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____ Date___/___/_____

Confidential Medical Information

Please state current problem(s): _____
_____

Are you currently being treated by:

Another Therapist ___Yes ___No or within the last 12 months ___Yes ___No
Chiropractor/Osteopath ___Yes ___No or within the last 12 months ___Yes ___No
Home Health Agency ___Yes ___No or within the last 12 months ___Yes ___No

Major surgeries since birth: _____

Allergies: _____

List current medications: _____

Check if you currently have or previously had any of the following:

☐ Arthritis
☐ Asthma
☐ Cancer
☐ Circulation Problems
☐ Diabetes
☐ Heart Problems
Specify: _____
_____
_____

☐ High Blood Pressure
☐ Gout
☐ Seizures
☐ Stroke
☐ Ulcers
☐ Other Illnesses
Specify: _____
_____
_____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature_____ Date_____

Patient Privacy Policy & Procedure Statement

Dear Patient:

Shoulder Elbow & Hand Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of you medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

Treatment of Minors: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____ **Initial**
Liability: I know and agree that SEH Rehab is not responsible for loss or damage to personal valuables. _____ **Initial**
Waiver and Release: I hereby release, discharge and acquit SEH Rehab, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency medical Technician, physician or urgent care services. _____ **Initial**
Authorization of Payment: I hereby assign all benefits directly to SEH Rehab and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in this statement. I understand fully that in the event my Insurance Company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____**Initial**

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 281-298-5811.

Thank you for choosing our health care facility.

Signature _____ Date _____

Patient/ Guardian