PATIENT REGISTRATION FORM
THE HAND CENTER OF SOUTHERN CALIFORNIA

Patient Name_____ Date of Birth_____

Address_____ Apt.#_____

City_____ State_____ Zip Code_____

Home Phone Number_____

Mobile Phone Number_____

Work Phone Number_____

Email Address_____

Driver License Number_____ Social Security Number_____

Emergency Contact_____

Phone Number_____ Relationship_____

Employer_____ Occupation_____

Address_____

City_____ State_____ Zip Code_____

Referring Physician_____ Phone Number_____

Diagnosis_____

I understand that regardless of any insurance coverage which I may have, I am directly responsible to The Hand Center of Southern California for any medical fees due to them. I authorize payment of medical benefits directly to them and authorize release of medical information necessary to process my insurance claims. I agree that a photocopy of this form may be used in lieu of the original.

Signature_____ Date_____

PLEASE ATTACH COPY INSURANCE ID CARD FRONT AND BACK

THE HAND CENTER OF SOUTHERN CALIFORNIA, INC

APPOINTMENT POLICY

We schedule your therapy appointments with an effort to ensure adequate time with the therapist. We make every effort to be on time and appreciate your timeliness as well.

We do understand that circumstances beyond your control may arise which may cause you to be late for an appointment.

If you are more than 10 minutes late for your appointment, we will make every effort to accommodate you. However, if it interferes with other patient's schedules or our operating hours, you will need to reschedule for another time.

If you cannot keep an appointment for any reason, please call 24 hours prior to your appointment. If you do not show for your appointment, or if you cancel 2 times with less than 24 hours notice our policy is to contact your insurance and doctor.

Please help us to keep the scheduling of appointments fair for everyone.

Signature_____Date_____

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact person. The name and address of the person you may contact for further information concerning our privacy practices is:

The Hand Center of Southern California
7120 Hayvenhurst Ave., Suite 215
Van Nuys, CA 91406
Attn: Rosemary Vargas

Effective Date. This notice is effective on or after April 15, 2003

Acknowledgement of Receipt of Notice of Privacy Practices

The Hand Center of Southern California reserves the right to modify the privacy practices outlined in the notice.

Signature. I have received a copy of the Notice of Privacy Practices for The Hand Center of Southern California.

_____
Name of Patient

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative (Required if the Patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient