MEDICARE PATIENT REGISTRATION FORM
THE HAND CENTER OF SOUTHERN CALIFORNIA

Date of First Visit_____ Date of First Prescription_____

Patient Name_____ Date of Birth_____

Address_____Apt.#_____

City_____State_____ Zip Code_____

Social Security Number_____

Driver License Number_____

Sex _____Male _____Female _____

Marital Status _____Single _____Married _____Divorced _____Widowed _____

Home Phone Number_____

Mobile Phone Number_____

Work Phone Number_____

Email Address_____

Emergency Contact Name_____

Phone Number_____ Relationship_____

Employer Name_____

Employer Address_____

City_____State_____ Zip Code_____

Referring Physician_____ Phone Number_____

Date of Last Visit_____ Diagnosis_____

Have you had Occupational Therapy this Year _____Yes _____No How Many Visits_____

Are You Enrolled in Medicare Home Health _____Yes _____No

PLEASE ATTACH COPY OF MEDICARE ID CARD AND SECONDARY 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

2022

Information Release Authorization

Company Name: The Hand Center of Southern California

I hereby consent to the release and disclosure of my personal health information to:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone #: ( )_____ **Fax #: ( )**_____

For the following purpose:

_____

_____

_____

This release authorization includes my personal health information consisting of:

_____

_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of the above practice having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

_____

Patient Name

_____

Signature *Date*

2022

PATIENT INFORMATION ACKNOWLEDGMENT FORM

COMPANY NAME: The Hand Center of Southern California

I have read and fully understand above named practice's Notice of Information Practices. I understand that above named practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that above named practice will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in above named practice's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

I also authorize above named practice to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____

Patient Name

_____

Signature

_____

Date

2022

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

Company Name: The Hand Center of Southern California

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date

2022 INSURANCE COVERAGE

Company Name: The Hand Center OF Southern California

Patient Name: _____

Insurance Company: _____

ID Number: _____

Deductible: _____ Amount Met: _____

Coverage: _____

Limitations: _____

Please review the above insurance information, which was verified with your insurance company.

Please note: Insurance companies often change their policies and coverage at the beginning of the New Year. As a reminder you are responsible for any amount applied toward your deductible and any amount not covered, for any reason, by your insurance company. We strongly recommend that you check with your insurance company to confirm your physical, occupational, and speech therapy benefits for 2022.

IT IS YOUR RESPONSIBILITY TO INFORM OUR OFFICE REGARDING ANY CHANGES.

Signature: _____ Date: _____

2022 Patient Signature

COMPANY NAME: _____

PATIENT NAME: _____

____ *Consent for Care and Treatment*

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

____ *Authorization for Signature on File and Release of Information*

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

____ *Authorization for Assignment of Benefits*

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to above named practice.

____ *Financial Responsibility*

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

____ *Cancellation Policy*

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. I, the undersigned, understand that I will be personally responsible for any cancellation fees.

____ *Reminder Message*

I, the undersigned, hereby authorize the office of above named practice to send reminders to my mobile number, home phone, or email address of upcoming appointments.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient or Guardian Signature Date

A. Notifier / Practice Name: The Hand Center of Southern California

B. PatientName: _____ **C. IdentificationNumber:** _____

2022 Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't payfor **D.** _____ below, you may have topay.

Medicare does not pay for everything, even some care that you or your health care providerhave good reason to think you need. We expect Medicare may not pay forthe **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
☐ 97012 Mechanical Traction	☐ Over Medicare Standard of Treatment	$: _____
☐ G0283 Electric Stim	☐ Not Covered procedure code	
☐ 97035 Ultrasound	☐ Not Medically Necessary_____	
☐ 97110 Therapeutic Ex	_____	
☐ 97112 Neuro Re-Ed	☐ Patient is enrolled under Home Health	
☐ 97116 Gait Training	☐ Maintenance program, no measurable progress being made	
☐ 97124 Massage	☐ Other: _____	
☐ 97140 Manual Therapy	_____	
☐ 97530 Therapeutic Activities	☐ OT Services $2150.00 Medicare Annual Maximum	
☐ 97535 Activities of Daily Living	☐ OT Services over $2150.00 up to $3000.00 are subject to the	
☐ 97033 Iontophoresis	Medicare Review Process for medical necessity through 12/31/2022	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about yourcare.
- Ask us any questions that you may have after you finishreading.
- Choose an option below about whether to receivethe **D.** _____ listedabove.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box foryou.

☐ **OPTION 1.** I wanttheD._____listed above. You may ask to be paid now, but I alsowantMedicarebilledforanofficialdecisiononpayment,whichissenttomeonaMedicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-paysor deductibles.

☐ **OPTION 2.** I wanttheD._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare isnot billed.

☐ **OPTION 3.** I don't wanttheD._____listed above. I understand with this choiceI am **not** responsible for payment, and I cannot appeal to see if Medicare wouldpay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.