DEBORAH AUSTIN OTR, CHT

Date: ____/____/____

Full Name: _____ Nickname: _____

Address: (skip if same as license) _____ City: _____ Zip: _____

Date of Birth: ____/____/____ Age: _____ Last 4 Digits of SS #: XXX-XX-____

Cell Phone: (____) ____-____ Work / Home Phone: (circle) (____) ____-____

Email for our office communication only: _____

☐ @GMAIL.COM ☐ @AOL.COM ☐ @iCLOUD.COM ☐ @YAHOO.COM ☐ @OUTLOOK.COM
☐ @ATT.COM ☐ @ATT.NET ☐ @HOTMAIL.COM ☐ @COMCAST.COM ☐ @VERIZON.COM

Referring MD: _____ Date of your last Doctor's Appointment for this condition: ____/____/____

Which body side is Injured (mark): ☐ Left ☐ Right Dominance (mark which hand you write with): ☐ Left ☐ Right

Date of Current Injury/Condition: ____/____/____ Date of surgery for this Condition: ____/____/____ ☐ N/A

Previous Surgical procedure(s) involving same hand: _____ ☐ N/A

How were you injured (auto accident, fall, etc.) _____ ☐ N/A

Where did injury occur (mark): ☐ Work ☐ Home ☐ Other: _____

Do you have any intention of pursuing legal action: ☐ Yes ☐ No

Do you have any intention of pursuing disability claim: ☐ Yes ☐ No

If (yes) please provide Attorney's Name: _____

Attorney's Phone Number: _____

Pertinent Allergies / Sensitivities (mark): ☐ Tape ☐ Lidocaine ☐ Cortisone ☐ Lotion ☐ Vitamin E ☐ Clinical Materials
☐ Silicone ☐ Neosporin ☐ Latex ☐ None ☐ Other: _____

Current Medical History (mark all that apply): ☐ Diabetes ☐ High/Low Blood Pressure ☐ Stroke/CVA ☐ Pacemaker
☐ Any Bleeding Tendencies ☐ Bruise Easily ☐ Fibromyalgia ☐ Cardiac History ☐ Metal Implants on Hand or Arm
☐ Reaction to Hot or Cold/Sensory Disturbances ☐ Cancer ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Osteoporosis
☐ Currently Pregnant ☐ None ☐ Other: _____

Address: 2061 Northwest Boca Raton Blvd Suite #106,
Boca Raton, FL 33431
Phone: (561) 362-8757 | Fax: (561) 362-8949

DEBORAH AUSTIN OTR, CHT

Insurance (mark your type of insurance coverage): ☐ Medicare Part B ☐ Medicare Advantage Plan ☐ Auto ☐ Self Pay

☐ Commercial (Includes all major Insurance) ☐ Workers' Compensation ☐ Other: _____

Medicare Patients Only:

Are you currently receiving home health care (mark one): ☐ Yes ☐ No

Permanent Residency State: _____

If your physician prescribed a DME (Durable Medical Equipment) Orthotic fabrication, and you have received a similar Orthotic in the past 2 years, you must notify us prior to dispensing as you may not qualify for Medicare reimbursement at this time. Please ask the office staff if you have any questions regarding your DME Benefits.

☐ Yes, I have received a similar Orthotic in the past 2 years ☐ No, I have not received a similar Orthotic in the past 2 years

Please note that it's your patient responsibility to notify our office if you don't have a supplemental insurance policy or if your supplemental insurance policy does not cover the annual Medicare deductible or if your supplemental policy has an additional annual deductible.

☐ Yes, my supplemental insurance covers the annual Medicare deductible.

☐ No, my supplemental insurance does not cover the annual medicare deductible.

☐ I am aware that my supplemental insurance also has an annual deductible or patient responsibility.

☐ I do not know the answer to this question.

Signature: _____

All Patients: Office Policy for Therapy and HIPPA Statement

As a courtesy, we will file with your insurance company. However, fees for service are due and payable at the end of each visit unless payment arrangements are made in advance. The patient is responsible for assisting in insurance verification, knowing their insurance restrictions, requirements and benefits payable. Please note that insurance authorization is not a guarantee of payment. 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. - For Medicare patients, the approved amount is accepted - I am responsible for the 20% co-pay and annual deductible if not covered by a secondary policy. ***Medicare-B patients must have a doctor's prescription.** If I am in Home Health Care during my visits to this facility and Medicare denies payment, the bill is my responsibility. **Appointments canceled in less than 24 hours may be subject to $25.00 charge and a $75.00 charge may apply for a no-show visit.**

I authorize the above company to release all medical and billing information (relating to therapy services) to my appointed insurance company and/or attorney I also authorize my physician or other medical institution to release my medical record or copies thereof which they may request.

Signature: _____

Guarantor if applicable: _____ Date: ____/____/____

Other than your referring MD, notate any other individual(s) that you give permission to release your patient records to on your behalf.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please return forms with license, insurance cards and MD Prescription

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Medicare Patients Only - Required paperwork on first visit - No exceptions unless you're providing an updated written copy at the first visit.

Please list including all knows prescriptions. (OTC) over the counters, herbals, and vitamin/mineral/dietary nutritional supplements.

Medication / Vitamins	Dosage	Frequency	Oral/ Injection/ Topical

☐ Copy of medicines/vitamins/pain pills are attached in the medical record

☐ No changes in any medicines since last update _____

☐ No medicines/vitamins/pain pills _____

Print Name: _____ **Date:** ____/____/____

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