Buzzards Bay Hand Therapy, LLC
119 Wareham Rd. Unit 107
Marion, MA 02738
(508) 748-3933
FAX: (508) 748-3944

Patient Information

Name: **Last**_____ **First** _____ **MI** _____ **Date of Birth:** _____
Mo. Day Yr.

Address:_____

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

Home Phone_____ **Work**_____ **Cell** _____

Sex: ☐ Male ☐ Female **Status:** ☐ Student ☐ Single ☐ Married

Employer_____ **Occupation**_____

Address_____ **Phone:** _____

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

General Information

Date of onset of problem_____**Surgery date**_____ **Last Dr's visit** _____

Referring Doctor_____ **Primary Care Physician**_____

Ongoing/New Problem _____ **Work Accident** ____ **Auto**_____ **Other**_____

If Work Comp: Claim Number_____
Adjusters Name_____ **Phone Number**_____

Insurance Information

Primary Insurance Company _____ **Policy/ID Number**: _____
Address _____ **PPO**_____ **HMO**_____ **Other**_____
Phone Number _____
Who is responsible for the account?
Name: Last_____**First**_____**Relationship to patient:**_____
Address_____
City_____**State**_____**Zip**_____

Secondary Insurance Company (if applicable)_____
Policy/ID Number_____ **Phone Number**_____
Address: _____**PPO**_____ **HMO**____ **Other** _____

We will need a copy of your insurance cards. Please give us new copies if insurance changes.

Medical Information

Surgical History	Date
❑ Joint Replacement	_____
❑ Shoulder Surgery	_____
❑ Knee Surgery	_____
❑ Neck Surgery	_____
❑ Back Surgery	_____
❑ Hand Surgery	_____
❑ Heart Surgery	_____
❑ Abdominal Surgery	_____
❑ Other	
_____	_____
_____	_____
_____	_____
_____	_____

Medical History

- ❑ Diabetes
- ❑ CVA/Stroke
- ❑ Heart Attack
- ❑ Pacemaker
- ❑ High Blood Pressure
- ❑ Anxiety/Depression
- ❑ Cancer
- ❑ Asthma/Bronchitis/Emphysema
- ❑ Head Injury
- ❑ Arthritis
- ❑ Seizures
- ❑ Fractures
- ❑ Allergies/Drug Reactions _____
- ❑ Other _____

Have you had Occupational or Physical Therapy within the last 12 (twelve) months? _____
If yes, state reason and dates:

_____

_____

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge **$25.00** for missed appointments per each half-hour scheduled. We have a 24-hour answering service. We may have patients waiting for appointments on a cancellation list. Your phone call allows us to schedule them. This charge is not covered by or billed to your insurance. If due, please pay it at the front desk before your next appointment. ***Your signature indicates that you understand our policy***.

ASSIGNMENT AND RELEASE

I authorize payments of benefits directly to **Buzzards Bay Hand Therapy** for services rendered. I also authorize release of my medical information that may be required in determination of such benefits.
I understand that some services may require approval of my primary care physician for coverage and that if I do not obtain that approval, I am financially liable for the services.
I understand that my insurance carrier may not cover some services and products and benefits obtained on my behalf. Deductibles and fees not paid by my insurance carrier will be my responsibility.
This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that the **Buzzards Bay Hand Therapy** Privacy Policy is displayed in waiting areas and that a copy of this policy is available to all patients.

I authorize **Buzzards Bay Hand Therapy** to disclose my medical information on my home answering machine/voice mail ☐ Yes ☐ No

I authorize **Buzzards Bay Hand Therapy** to disclose my medical information to the person(s) listed herein:

_____

_____

Signature_____ **Date**_____

Signature of Guardian/Personal Representative _____**Date** _____

Relationship to Patient _____