Laura McCarthy OTR CHT PA
5086 Dorsey Hall Drive, Suite 106, Ellicott City, MD 21042
410.997.0037 Phone | 410.997.3510 Fax | www.lbhandtherapy.com

PATIENT REGISTRATION FORM

LAST NAME:		FIRST NAME:		MI:			
IF MINOR, PARENT OR GUARDIAN:							
ADDRESS:				APT:			
CITY:		STATE:		ZIP:			
TELEPHONE:		CELL:					
EMAIL:							
DOB:		GENDER:	☐M ☐ F	MARITAL STATUS:	☐S ☐M ☐W ☐D	S.S. Number:	
REFERRING DOCTOR:		STUDENT STATUS:	☐ NON-STUDENT ☐ FULL TIME ☐ PART TIME				
INSURANCE CARRIER:	☐ AETNA ☐BC/BS (including HMO's) ☐ CIGNA ☐ MEDICARE ☐ TRICARE ☐ WORKERS COMP						
INSURANCE 1:		INSURED'S NAME:					
INSURANCE NO.:		INSURED'S DOB:					
POLICY TYPE:	☐ AUTO-PIP ☐ WORKERS COMP ☐ GROUP NO.						
INSURANCE 2:		INSURED'S NAME:					
INSURANCE NO.:		INSURED'S DOB:					
POLICY TYPE:	☐ AUTO-PIP ☐ WORKERS COMP ☐ GROUP NO.						
Was this injury related to a Motor Vehicle Accident? ☐YES ☐ NO If so, when?							
Was this injury related to employment? ☐YES ☐ NO If so, when?							
Has patient received HOME HEALTH SERVICES? ☐YES ☐ NO If yes, bring a copy of discharge summary to first visit.							
DIAGNOSIS:							
Do you need an Orthosis (splint) fabricated? ☐YES ☐ NO							

EMERGENCY CONTACTS:	NAME	RELATIONSHIP	PHONE
WHO MAY WE CONTACT IN AN EMERGENCY?			
PRIMARY PHYSICIAN:			

WOULD LIKE TO RECEIVE AN AUTOMATIC NOTIFICATION OF YOUR UPCOMING APPOINTMENTS? IF YES, PLEASE CHECK THE APPROPRIATE BOX.	☐ NOTIFY BY EMAIL ☐ NOTIFY BY TEXT		
SCHEDULED APPOINTMENT:		WITH: ☐ LAURA ☐ JULIE	
TOLD TO BRING RX, INSURANCE INFORMATION, AND CALENDAR TO FIRST VISIT? ☐YES ☐ NO		GIVEN DIRECTIONS? ☐ YES ☐ NO	

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Complete the following for recurring copays that you wish to charge to your credit card or Healthcare Savings Account:

Credit Card: ☐ Visa ☐ American Express ☐ Master Card ☐ Discover

Credit Card Number: _____

Name on the Card: _____

Expiration Date: _____ CSC (last 3 digits on back of card): _____

How did you hear about us? ☐ Friend ☐ Physician ☐ Internet/Website

☐ Previous Patient ☐ Other _____

I understand that I may refuse any treatment at any time. I also give my permission to LB Hand Therapy to bill my insurance company on my behalf. I recognize that this is a courtesy and that I am responsible for all charges incurred for my treatment.

I understand that a $50.00 fee will be charged to my account for cancellation of a scheduled appointment without providing 24 hours advance notice.

I understand that I am responsible for the copays, deductibles, coinsurances, and non-covered items not paid by my insurance company. Supplies not covered by my insurance company may be billed to my account. If I don't have insurance, I understand that I am responsible for all charges. I understand, that where indicated, my credit card may be charged. I also understand that if collection proceedings are started against me, I am responsible for all legal fees, court costs, collection costs, and interest on the balance on the account. Please be aware that due to the reduction in fees from the health care reform, we will not be able to wait for litigation to get paid in accident cases. Please make payment arrangements and you can be reimbursed once your court case has settled.

I have been shown the HIPPA privacy agreement and have been given the opportunity to read the policy.

_____ _____

Signature **Date**

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Notice of Privacy Practice (HIPAA) for LB Hand Therapy

LB Hand Therapy, (Laura McCarthy, OTR, CHT, PA), is required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payments for your health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. LB Hand Therapy must comply with the provisions of this notice, although, LB Hand Therapy reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information LB Hand Therapy maintains. You can request a copy of our most current privacy notice from this facility at any time.

Permitted Uses and Disclosures

1. Coordination of treatment with other health care providers.
2. Payment of claims by your insurance carrier or third party payer.
3. Family or friends involved in your direct care, if there is a signed release.
4. Worker's Compensation benefits coordination and payment.
5. Public Health Authorities to control or prevent disease, injury, disability, deaths, abuse, or neglect.
6. Health oversight by state or federal authorities that monitor health care programs for compliance with government regulation and civil rights law.
7. Lawsuits and disputes with appropriate subpoena or administrative order.
8. Law Enforcement to aid in the search of a criminal or fugitive or criminal investigation.
9. Coroners, Medical Examiners, and funeral directors in order to identify a deceased person determine the cause of death, and to assist funeral directors in carrying out their duties.
10. Purpose of national security authorized by federal authorities for national security activities permissible by law.

As permitted by applicable law and ethical conduct, LB Hand Therapy may use and disclose medical information if its staff believes, in good faith, that such use or disclosure is necessary to prevent serious harm to you and to others. Other uses and disclosures of your protected health information will be made with your authorization, and you reserve the right to refuse such authorization.

Your Rights

As a patient of LB Hand Therapy, you have the right to:

1. Request restrictions on our use of your medical information for any of the services listed above, however, LB Hand Therapy is not required to accept your request.
2. Request confidential communication of your protected health information.
3. Request copies of your medical information to be delivered to other locations. You will be responsible for any expenses incurred by us for these alternative services, i.e., copying and mailing records return receipt requested.
4. Request to view your medical records.
5. Request an addition or amendment be made to your medical information, subject to certain restrictions.
6. Request the Notice of Privacy Practices in a paper copy.

LB Hand Therapy Service's Duties

We are required by law to maintain the privacy of your protected health information and to provide you with a copy of our Privacy Practices. We are required by law to abide by the statements within this Notice of Privacy Practices, effective April 14, 2003. LB Hand Therapy reserves the right to make any necessary changes and updates to our Privacy Practices, and these new provisions effect all protected health information that we maintain. Should we see the need to change our Privacy Practices, an updated Notice of Privacy will be mailed to all current patients of LB Hand Therapy.

Should you have a concern, question, or feel your privacy rights have been violated, please contact me, Laura McCarthy, OTR, CHT, at (410) 997-0037. You may also file a complaint with the Department of Health and Human Services.

☐Patient gives office permission to leave a message on their answering machine
☐Patient gives permission to discuss their medical condition with another person

_____ _____

Signature **Date**

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PATIENT PARTICIPATION AGREEMENT

We at LB Hand Therapy appreciate the opportunity to work with you to address your rehabilitation needs. Our therapists promise to devote their energy and skill to maximizing your recovery process. We share your goal of achieving an optimal outcome, as well as the responsibility of doing what is necessary to obtain that goal.

_____(Patient initials)

Following the initial evaluation, you and your therapist will formulate a treatment plan based on the evaluation findings and the initial prescription from the referring physician. Your therapist is responsible for recommending an appointment schedule (i.e. frequency and length) and it is your responsibility to discuss this proposed schedule and come to an agreement on a schedule that you can adhere to. Your therapist is also responsible for trying treatments and changing the treatment plan if it is not working for you.

_____(Patient initials)

In order to maximize the benefits of therapy, it is important that you keep your therapist informed of the effects of any treatment technique so appropriate modifications may be made. You will assume the responsibility for participating in a home exercise program and for making the necessary behavioral changes that will support your body in the healing process. Lastly, you will be expected to attend all of your scheduled appointments.

It is essential for you to keep your appointments. We pride ourselves on being a facility that runs on time. We are able to do this because we do not overbook our patients. Unfortunately when patients don't give sufficient notice or don't show up for their appointments our therapists are left with no one to treat even though there are patients waiting to get into the schedule. Your assistance is necessary in order for our facility to provide quality services to all those in need.

_____(Patient initials)

Cancellations – No Shows – Fees

- Please understand that missed appointments have an impact on the clinic as well as other patients. Therefore a 24 hour notice for cancellations is requested. Cancellations made after 24 hours are subject to a cancellation fee of $50.00. This charge must be paid by you – neither your insurance nor Worker's Compensation will cover this charge.

- In order to accommodate other patients, if you do not call or show up for two appointments, you will be discharged from therapy and your doctor and/or nurse case manager will be notified.

Your active participation in the rehabilitation process is a vital component of your recovery. Please assist us by making arrangements to keep all of your scheduled appointments. Thank you.

_____ _____
Patient Signature Date

OR

_____ _____
Parent or Legal Guardian Signature Date

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Medical Information

Patient:_____ Date:_____
Age:_____ Date of Birth:_____ ☐ Male ☐ Female
Hand Dominance: ☐ Right ☐ Left Height: Feet___Inches___Weight:_____pounds

List of Medications

Name	Dosage	Frequency	Delivery Route	Treatment For:

If additional space needed turn page over.

Do you have a pacemaker, internal defibrillator, insulin pump or other implanted medical device?☐ Yes☐No
If yes, please specify:_____

What are you seeking treatment for?_____
_____

What goals do you hope to achieve with therapy?_____
_____

Is the current problem a result of a work related injury? ☐Yes ☐No Date of injury:_____
Is the current problem a result of a motor vehicle accident? ☐Yes ☐No Date of accident:_____

Referring Physician Name:_____ Phone:_____
Primary Care Physician Name:_____ Phone:_____

Anything else you would like to tell us?_____

LBHANDTHERAPY
LAURA MCCARTHY OTR CHT
5086 Dorsey Hall Drive, Suite 106, Ellicott City, MD 21042
(410) 997-0037 Telephone | (410) 997-3510 Fax | www.lbhandtherapy.com

Patient Name:_____

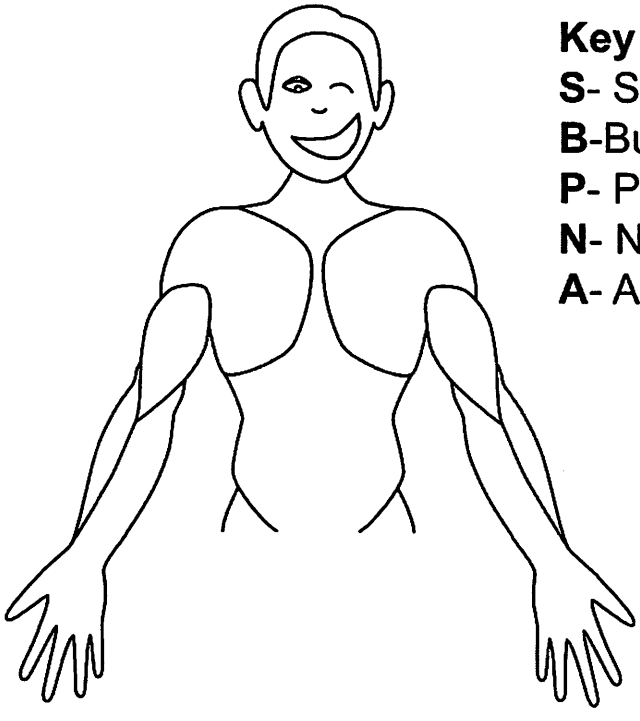
Date:_____

Pain Range: Please mark pain level you are currently experiencing on line below

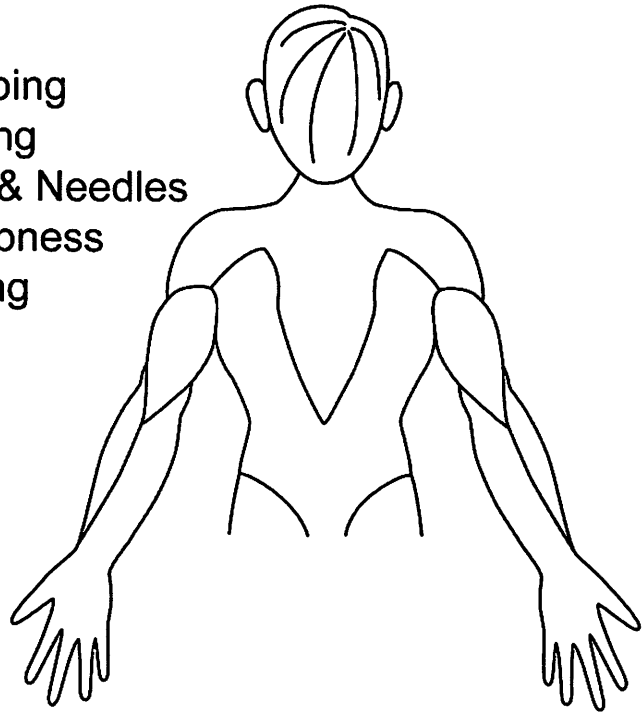
0
No Pain

10
Severe Pain
Call 911

Location of Pain: Please mark location of pain using description from key



Key
S- Stabbing
B-Burning
P- Pins & Needles
N- Numbness
A- Aching



Patient Signature:_____

DISABILITIES OF THE ARM, SHOULDER AND HAND

Name: _____ **Date:** _____

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

Disabilities of the Arm, Shoulder and Hand

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? *(circle number)*	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\left[\left(\frac{\text{sum of n responses}}{n}\right) - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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