PATIENT INTAKE FORM

PATIENT INFORMATION

Name Last ___________________________First ________________________ MI ______ Date _____________________

Address ____________________________________City _________________________ State ________ZIP____________

Home Phone _______________________ Cell _________________________ email _______________________________

Male _____ Female _____Student _____Single _____ Married _____ Divorced _____ Widowed _____ Separated ______

Date of Birth (mm/dd/yyyy): _____/_____ /_________ DL # _______________________________ State_____________

Employer/Occupation ____ Phone ______________________

Employer Address _________________________________City ____________________State ________ZIP ___________

GENERAL INFORMATION

Doctor ____ Phone ____

Description of Problem ____

Date of Onset _________________________ Have you had Surgery? Y____ N ____ If yes, when? _____________________

LOCAL CONTACT IN CASE OF EMERGENCY

Name ___________________________________ Relationship ____________________ Phone _______________________

SUPPLIES AND EQUIPMENT

________ I understand that there are no returns or reimbursements on custom made splints that are fabricated and molded to specifically fit me and my condition; prefabricated (non-custom) have a 7-day return policy provided they are returned with the original packaging. I understand that GRASP hand therapy does not have a contract with my insurance company to provide supplies, orthotics, braces, equipment or any durable medical goods. I agree to pay for these supplies and equipment in full on the date of services. I also understand that it is my responsibility to pay the cost of replacement splints that are lost, stolen or destroyed.

________ I understand and agree that payment for services rendered and supplies/equipment provided by GRASP hand therapy are due and payable in full at the time of treatment. I understand that a $30 fee will be charged for appointments cancelled with less than 24 hours' notice.

________ I grant permission for GRASP hand therapy to perform a hand therapy evaluation and treatment during which the nature of the procedures that will be performed as well as the potential risks of care will be explained. I understand these risks and agree to allow GRASP hand therapy to perform the procedures as described.

Patient/Guardian Signature: Date: