THE THERAPY SOURCE, INC. d/b/a
HAND REHABILITATION & ORTHOTIC SPECIALISTS
6480 HARRISON AVENUE • SUITE 301 • CINCINNATI, OH 45247 • PHONE: (513) 574-5400 • FAX: (513) 574-6222

WELCOME TO HAND REHABILITATION & ORTHOTIC SPECIALISTS

Our Certified Hand Therapists specialize in Hand & Upper Extremity (hand to shoulder) rehabilitative therapy services and the fabrication of custom splints and removable/washable casts for the upper and lower extremities. Our mission is to assist your return to the highest level of normal functioning.

Your physician has referred you to Hand Rehabilitation for therapy and/or splinting or casting. ***Hand Rehabilitation & Orthotic Specialists is a separate and distinct company not affiliated with your referring physician or any other medical group.*** You are under no obligation to use our services and may choose to obtain services elsewhere. Patients may choose where they want to receive medical/rehabilitative services.

Generally, therapy services are covered under Occupational Therapy (OT) benefits; splints/casts are covered under Durable Medical Equipment (DME). We will file all claims with your insurance carriers. You must present any secondary and tertiary (supplemental) policies on the first date of service. **Claims are billed under: Hand Rehabilitation & Orthotic Specialists/The Therapy Source, Inc.**

Our Administrative Staff is very knowledgeable in discussing all insurance types. While we will attempt to obtain your insurance benefits as soon as possible, it is ultimately the patient's responsibility to know their policy benefits and limits.

Insurance does not cover 100%. You will be responsible for the following on the day of service.

Deductibles/Copays/Co-insurance and Therapy Supplies such as:
Compression Gloves, Pre-fabricated Splints, Putty, Pulleys, Wound Care Supplies, etc.

______ I understand and agree to therapy treatment in an open form. Private sessions available upon request.

______ I understand my medical benefits through ____________________________ or I am Self Pay ________.
Insurance Company Name

MEDICARE PATIENTS:

I am currently receiving Skilled Nursing or Home Health Services (circle) Yes No

______ I have read, understand and agree to the Financial Policy printed on the back of this form.

______________________	______________________	__________
Patient Signature	**Printed Name**	**Date**

______________________	__________
Administrative Staff Member Signature	Date

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FINANCIAL POLICY

The Therapy Source, Inc. (doing business as) Hand Rehabilitation & Orthotic Specialists is an Ohio-licensed corporation that adheres to basic business principles for the benefit of its customers, employees and the community it serves. Accordingly, it recognizes the need for definite understanding between our patients and this office regarding financial arrangements for rehabilitative care. We have established the following financial policies in response to those needs. It is our hope that you will understand that these payment collection practices are a necessary part of assuring the financial resources required to provide the best therapeutic care to our patients.

Private Insurance, Anthem, Humana, United Healthcare, Etc. - As a patient you are responsible for verifying your coverage. We will attempt to verify your insurance benefits if at all possible prior to your appointment. However, benefits cannot be absolutely verified until the claim is processed. We are an in-network provider for most insurance companies. If we are out of network, you are responsible for fees not covered by your insurance.

Medicare/Medicaid – We are a provider for Medicare/Medicaid. Therapy is covered under Occupational Therapy benefits; Splints/Casts are covered under Durable Medical Equipment (orthotics). Limitation on Medicare coverage: **If the patient is currently receiving any SKILLED NURSING or HOME HEALTH CARE services and is seeking therapy at our clinic, you must speak with the Administrator prior to starting therapy services.**

Workers' Compensation – We are a certified Ohio Bureau of Workers' Compensation provider and will process billing for allowed claims. If a Claim is ultimately disallowed, fees for services provided will be the patient's responsibility.

Self Pay (paid in full at time of service) - Patient pays all charges in full by cash, check or credit card at the time of service. Self-pay patients can receive a DISCOUNT up to 30% off charges. This option is available to all patients who do NOT want any third party (insurance, Attorney, ETC.) to be billed. *Patients using MedPay with approved Homeowner or Automobile claims must arrange for direct payment verified by in writing for payment of services with the Administrator prior to beginning treatment. If your claim is not settled you will need to provide payment at time of service.*

Auto/Third Party Payers - We do NOT file any insurance with your automobile/third party (business insurance company, employer, attorney, etc.) accident cases. We will make every effort to provide you with proper documentation for you to receive reimbursement. We do not accept Letters of Guarantee or other promises to pay when cases settle. Patients will need to obtain a subrogation form from their personal health insurance.

Fee Schedule - Our fee schedule is based on HIPAA-approved CPT (Current Procedure Terminology), HCPCS (Healthcare Common Procedure Coding System, ABC (Advanced Billing Concepts), and Medicare fee schedule guidelines.

Deductibles/Copays/Co-insurance - Due at time of service.

CANCELLATION/NO SHOW – Patient agrees to pay a $35 fee for all cancellations made less than 24 hours in advance. No shows are charged at $35. Payments must be satisfied prior to the next therapy appointment before receiving services.

Payments accepted - We accept CASH, CHECK and CREDIT CARDS (Visa, MasterCard, Discover). Credit card payments may be made via telephone. Returned checks will incur a $30.00 service charge.

Patient Statements - Patients will be billed monthly after receipt of insurance payment(s) for patient balance. Balance is due in full upon receipt of statement. Late fees may be assessed for balances past due.

Collections - Accounts will be placed for collections after 2 statements and will be charged an additional $25.00 for collection and attorney fees.

Credit Balances - All patients may inquire if any credit balance exists in their account. They will be refunded promptly.

Financial Questions or Concerns - Call our Clinic Manager at (513) 574-5400. I agree to be responsible for payment of all services rendered on my behalf or my dependent's. I acknowledge and agree to my obligations under this Financial Policy.

HAND REHABILITATION & ORTHOTIC SPECIALISTS

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Social Security Number ______________________ Date of Birth ____________________ Gender: Female Male

Name of Patient ______________________________________ Email ____________________________

Address ____________________________ City ____________________ State _____ Zip code ______________

Home Phone ( ) __________________ Cell Phone ( ) __________________ May we leave a message at the # provided? Y N

Occupation: ______________________________ Employer Name/Phone: ______________________________

Employer Address: ___________________________ City: __________________ State: _____ Zip code: ___________

Injury/Condition Info: Diagnosis Right ___ Left ___ ______________________________________ Hand Dominance R L

Referring MD ___________________ Date of Injury __________________ Date of Surgery __________________

How injury occurred: Accident Auto Fall Sports Work Other (please explain) ______________________________

Have you received any Occupational or Physical Therapy this year? Y N If yes, how many sessions? OT_____ PT _____

Medical History (please circle): tobacco user live alone h/o falls recent fall DMI DMII Fibromyalgia Cancer EDS/hypermobility

Osteoarthritis Rheumatoid Arthritis High/Low Blood Pressure Any heart conditions/Other: ______________________________

Traumatic Brain Injury Stroke Depression/Anxiety Seizures/Epilepsy Blackouts/Dizziness Dementia/Memory Loss Orthopedic Injuries

Other/Details: ____

Medications/Dosage: ____

______________________________________Allergies: Latex Adhesives Peanuts Other __________________

Pain Scale/Location ______________________________Burning Throbbing Achy Sharp Numbness/Tingling __________________

Worst: 0 ! 2 3 4 5 6 7 8 9 10 Current: 0 1 2 3 4 5 6 7 8 9 10 Best: 0 1 2 3 4 5 6 7 8 9 10

MEDICARE PATIENTS – Skilled Nursing or Home Health Services? Y N If yes, name of Facility/Company ______________________

Primary Insurance

Name of Insurance ______________________________________ Policy Number ______________________________

Policy Holder name ________________________________ Date of Birth _________________ Relationship ______________

Address of Policy Holder/Guarantor (if different from patient) ____

City ________________________ State _______ Zip ______________ Phone ______________________________

Secondary Insurance

Name of Insurance ______________________________________ Policy Number ______________________________

Policy Holder name ______________________________ Date of Birth ____________ Patient's Relationship _______________

Office Staff Only:

Primary Ins Benefit Info

Elig Date: ___/___/___ OT: $_______ded $_______met ___/___% co ins $_____copay Visits: _____allowed _____used

DME: $_______ded $_______met ___/___% co ins Auth Requirements: ______________________________________

If Workers' Compensation

Date of Injury _______________ Claim # _________________ Approved Dx Codes ______________________________

Name of Case Manager ____________________________ Phone ( ) _________________ Fax ( ) ______________

WC MCO/TPA Name ______________________________ Phone ( ) _________________ Fax ( ) ______________

Claims Address ____

******************ALL WORKERS' COMPENSATION CLAIMS MUST BE APPROVED & TREATMENT MUST BE AUTHORIZED******************

HROS ADMIN: Appt Date/Time __________________________ Location __________________ Admin initials _____________

Consent for Evaluation/Treatment:

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. **I consent to receive services provided by Hand Rehabilitation & Orthotic Specialists. These services will include an evaluation and treatment as recommended by my physician after consultation with the appropriate therapists. Treatment will be consistent with a plan of care developed by the therapist with my input. I acknowledge that I have been informed of the risks and benefits of treatment and my right to refuse or withdraw consent for treatment.**
2. **I authorize Hand Rehabilitation & Orthotic Specialists to release any information required for payment or insurance claims.**
3. **I authorize my Insurance or Medicare benefits to be paid directly to Hand Rehabilitation & Orthotic Specialists, realizing I am responsible to pay non-covered and authorized services. I understand that I am responsible for all charges incurred through Hand Rehabilitation & Orthotic Specialists. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.**

______________ Initials for Consent

HIPAA

I acknowledge that I have read (or have been offered) the Health Insurance Portability & Accounting Act of 1996 Privacy Notice & Patient's Rights. I understand that I may request a copy of this document.

______________ Initials for HIPAA

Designation of a Personal Representative/Emergency Contact

A patient may designate a personal representative in writing. A personal representative may be a spouse, adult, child, or other member of the patient's family. A personal representative also may be a close personal friend or any individual with power of attorney or to any legally recognized authority to make medical decisions on behalf of the patient if he or she is incapacitated or otherwise unable to make decisions. A parent or legal guardian of a minor will be recognized as a personal representative of the child, and consent must be provided for treatment of a child at every visit.

A personal representative may act on behalf of the patient for the purpose of receiving information that otherwise would be given to the patient. Such information could include: appointment changes, messages regarding treatment, Hand Rehabilitation & Orthotic Specialists response to phone messages, or insurance or billing information. Please note, an answering machine cannot be used as an acceptable way of leaving information. A staff member may refuse to disclose information to a person identified as a patient's personal representative if he/she believes such information should be given directly to the patient.

Persons to whom my information may be disclosed/Emergency Contact

Name ______________________________ **Relationship** ______________________

Home Phone (   ) ______________________ **Work/Cell Phone (   )** ______________________

Other ______________________ **Relationship** ______________ **Phone (   )** ______________

By the signature below, I attest that the information I have provided is complete and accurate.

Signature ______________________________________ **Date** ______________________

***Responsible* Party Signature (if patient is minor)**