Shoulder and Hand Therapy Center

Ron French, OT, CHT
849 Volunteer Dr. STE 8
Paris TN 38242

Patient Information

Full Name: _____ Date: _____
First *M.I.* *Last*

Parent or Guardian if minor: _____ Relation: _____
First *M.I.* *Last*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Email: _____

Cell Phone: _____ Work: _____

Date of Birth: _____ Age: _____ Gender: _____ ☐Single ☐ Married ☐ Other

Employer/School: _____

Emergency contact: _____ **Phone:** _____ Relation: _____

Whom may we thank for referring you? _____

Preferred Method of Contact

We sometimes need to call regarding appointment times, please list your preferred contact method…

☐ PHONE What is your preferred contact #? Home – Cell - Work *List number if different from above:* _____

May we leave a message? NO ☐ YES ☐ *Comments:* _____

☐ TEXT Cell phone # *(if different from above)*: _____

☐ EMAIL*(if different from above)*: _____

Coordination of Care

We will send progress notes to your referring doctor, so please keep us updated on your appointments with the doctor that sent you to therapy. If you would also like these notes to be sent to your primary care physician, please list here:

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

Insurance Authorization, Assignment of Benefits, Financial Responsibility

Insurance Co: _____ ID Number: _____ Group #: _____
Subscriber (if other than patient): _____ DOB: _____ Relation: _____

- I authorize use of my signature on all insurance submissions.

- I understand that my healthcare information may be disclosed to my insurance company(s)and their agents for the purpose of obtaining payment for services and determining insurance benefits.

- I assign directly to Ron French, OT, CHT/Shoulder and Hand Therapy Center, all insurance benefits for services rendered.

- I understand that I am ultimately financially responsible for all charges whether or not paid by insurance.

-This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____ Date: _____
Patient, Parent, Guardian, or Personal Representative

Print name: _____ Relation: _____

Privacy Policy / Treatment in Open Setting

1) I have received a copy of the *Notice of Privacy Practices* for the Shoulder and Hand Therapy Center and I have been given an opportunity to review and ask questions regarding the notice. I understand what is included in my medical records, how my medical information may be disclosed, my rights concerning my medical information, and how I may voice my concerns.

2) I understand that my treatment may be performed in an open setting and may occur in the presence of other individuals. And by signing this form, I acknowledge that it is possible that other patients, family members, friends, or staff may overhear information relating to my treatment, diagnosis, and insurance benefits.

Signature: _____ Date: _____
Patient, Parent, Guardian, or Personal Representative

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Notice of Privacy Practices

This Privacy Notice applies to all your health information including your records at the Shoulder & Hand Therapy Center/Ron French, OT, CHT and health care records received by us from other sources necessary to provide proper care. We are required by law to keep your PHI confidential and give you a copy of this notice.

How we may use and disclose your Protected Health Information.

- For Treatment: We may use or disclose your PHI to other healthcare professionals involved in your health care.
- For Payment: We may use or disclose your PHI to your insurance company or representative to obtain approval of treatments or get payment for services we provide for you.
- For Health Care Operations: We may use or disclose your PHI to review our services and programs.
- For Appointment Reminders: We may use or disclose your PHI to contact you as a reminder that you have an appointment for treatment.
- For Marketing: We may use or disclose your PHI to contact you about open houses or events we are participating in within the community. We do not sell your information to other entities.

The law provides that we may use or disclose your PHI from our records (even after your death) without your permission in the following circumstances:

- As Required by Law: We may disclose your PHI when required to do so by law.
- Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by the law. These include audits, investigations, inspections, etc., necessary to govern or monitor the healthcare delivery system.
- Public Health Risks: We may disclose your PHI for public health activities such as the tracking, prevention, or control of certain diseases, injuries, and disabilities.
- To Avert a Serious Threat to Health or Safety: We may disclose or use your PHI, if necessary, to prevent a serious threat to you or the health and safety of the public or another person.

Your rights regarding your health information

- Right to inspect and copy: In most cases, you have the right to look at or get copies of your records. You must make the request in writing and you may be charged a fee for the cost of copying your records.
- Right to Amend: If you feel there is an error or missing information in our records, you must request a change in writing, and provide a reason that supports your request. We may deny your request. We will state the reasons for denial and explain your rights to have the request and denial appended to your PHI.
- Right to Know What PHI We Have Released: You have the right to request in writing, a list of disclosures we made of your PHI for purposes other than those listed in the Privacy Notice. You must state the time period the list should cover (no longer than six years back).
- Right to Request Restrictions; You have the right to ask us to limit how your PHI is used or disclosed. You must make the request in writing and tell us what information you want to limit and to whom the limits apply. Please note that we are not required to agree to your request. If we do comply with your request, we will do so unless the information is needed to provide you with emergency care.
- Right to Confidential Communications: You have the right to request that we communicate with you in a certain way or at a certain place, i.e. you may want to use your work address/phone instead of home. You must make this request in writing; no explanation is required. We will honor all reasonable requests.
- Right to Authorize a Release of PHI: You may make other request for your PHI, in writing, and you can change your authorization at any time.
- Right to a Paper Copy of this Notice: You have the right to request a copy of this notice at any time. We have the right to change our privacy practices/notice at any time. We will post a copy of the current notice in our office.

If you have any questions about this notice, please contact our Privacy Officer. If you believe we have violated your privacy rights, you may file a written complaint to our Privacy Officer. Your care will not be affected by filing a complaint.

Privacy Officer/SHTC
849 Volunteer Dr. Suite 8, Paris, TN 38242 - Phone: 731-642-0778

MEDICAL HISTORY FORM

Name: _____ Today's date: _____

Dominant hand: ☐ Right ☐ Left

Referring doctor's name: _____Next appointment: _____

Work Information Are you currently employed? ☐ Full-time ☐ Part-time ☐ No ☐ Student ☐ Retired Job title: _____

List your normal job functions ? _____

Lifting:		Pushing:		Pulling:		Overhead:	
Weight	*/ how often*	*weight*	*/ how often*	*weight*	*/ how often*	*weight*	*/ how often*

Current work status: ☐ Full-duty ☐ Light-duty ☐ Off-duty ☐ One-handed ☐ With restrictions:_____

PAST MEDICAL HISTORY:

Please check if you are a ☐ Non-smoker ☐ Smoker

Please circle/list any past or current medical conditions:

Heart disease	High blood pressure	Stroke	Diabetes 1 or Diabetes 2; Complications:
Pacemaker/Defibrillator	Irregular heart rate	COPD	Arthritis: Osteo or Rheumatoid
Gout	Neck pain	Back pain	Cancer, type: Year:
Head injury, date:	Other:		

Please list any previous neck, shoulder, arm, or hand injuries and/or surgeries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

List any metal implants or artificial joints? ☐ No ☐ Yes: _____

List any allergies: _____

Please list *ALL* Medications, Over-the Counter medicines, Vitamin/Mineral Supplements & Herbal Supplements (even if you only take them occasionally as needed for headache, seasonal allergies, etc.):

Name	Dosage	Frequency	Type (please circle)
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:

Continue on back if needed…

Date of surgery, if applicable: _____ Are you under any medical restrictions? ☐ Yes ☐ No

If yes, please list:_____

Briefly describe your symptoms: _____

When did symptoms start? _____ How? _____

How often do you experience your symptoms? Constantly - Frequently – Occasionally - Intermittently

What activities are you having difficulty with? _____

_____

Describe your pain: _____ Where does it hurt? _____

_____

Please rank your pain, zero is no pain and 10 is the worst pain:

Last 24 hrs.: (no pain) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (worst)

Past week: (no pain) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (worst)

QuickDASH functional assessment questionnaire. Please answer every question based on your condition in the last week, making your best estimate of the most accurate response, regardless of which hand or arm you use to perform the activity.			
1. Difficulty opening a tight or new jar? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	2. Difficulty doing heavy chores (wash floors, walls)? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	3. Difficulty carrying a shopping bag or briefcase? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	4. Difficulty washing your back? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable
5. Difficulty with activities that take some force or impact through your arm, shoulder, or hand (golf, hammering, tennis)? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	6. During the past week, to what extent has your arm, shoulder, or hand problem interfered with your normal social activities with family, friends, neighbors, or groups? ① Not at all ② Slightly ③ Moderately ④ Quite a bit ⑤ Extremely	7. 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? ① Not at all ② Slightly ③ Moderately ④ Very ⑤ Unable	8. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand? ① None ② Mild ③ Moderate ④ Severe ⑤ So much that I can't sleep
9. Difficulty using a knife to cut food? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	10. Tingling (pins & needles) in your arm, shoulder, or hand? ① None ② Mild ③ Moderate ④ Severe ⑤ Extreme	11. Arm, shoulder, or hand pain? ① None ② Mild ③ Moderate ④ Severe ⑤ Extreme	*For office use:* *((_____/11) -1) x 25 =* *Todays' score:* _____

What are your goals for therapy and/or any activities or hobbies you are having difficulty with due to injury ?

_____

_____

_____

- Thank you -