Notice Of Privacy Practice

This is to certify that I have been given or have been offered a copy of the NOTICE OF PRIVACY PRACTICE.

I have accepted a copy of the NOTICE OF PRIVACY PRACTICES.

Please read over the following and initial:

Consent to Treatment: I consent to rehabilitation and related services and related services Michigan Orthopaedic Rehabilitation/ Michigan Hand Therapy in so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of sensitive nature. _____

Treatment of Minors: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

Liability: I know and agree that Michigan Orthopaedic Rehabilitation/ Michigan Hand Therapy is not responsible for loss or damage to personal valuables. _____

Waiver and Release: I hereby release, discharge and acquit Michigan Orthopaedic Rehabilitation/ Michigan Hand Therapy, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, Physician, or urgent care services._____

In addition we cannot provide infant and child care. Thus for safety concerns, children MUST be supervised at all times, in treatment and waiting areas. Children are NOT allowed in the gym unless they are a patient accompanied by a therapist. _____

Below, please list the names and phone numbers of those you give permission to share your health information with.

Names:	Relationship	Phone Number
1.		
2.		
3.		

Print Name:_____ Date of Birth: _____

Patient/Guardian Signature:_____ Date: _____

By typing your name above, you agree that your typed signature can be used as your actual signature.

Registration Form

Patient Name: _____
(Last) (First) (Middle Initial)

Nickname:_____ Date of Birth:_____ Age:_____ Gender:_____

Address:_____

City:_____State:_____ Zip:_____

Home #: _____ Cell #: _____

Email Address: _____

Student: Y/ N Occupation: _____ Current Work Status: _____

Emergency Contact Name: _____

Relationship to Patient: _____Phone Number: _____Marital status:_____

Date of Injury/Onset of Symptoms: _____ Date of Surgery:_____

Referring Physician:_____ Phone #: _____

Date of Prescription:_____ Date of next Physician Visit:_____

- **Are you receiving or have you recently received home health services?** ☐ Yes ☐ No
- **Are you receiving or have recently received other therapy services?** ☐ Yes ☐ No
- **Have you had physical therapy, speech therapy, occupational therapy or chiropractic care provided in your home or in a clinic in the last 12 months?** ☐ Yes ☐ No

How did you hear about Michigan Orthopaedic Rehabilitation/ Michigan Hand Therapy?

Important! Please Read & Sign

By signing below, I agree that all of the above information is correct, and that I authorize Michigan Orthopaedic Rehabilitation/ Michigan Hand Therapy to provide me with therapy services and to furnish my Physician, insurance company, worker's comp carrier or attorney information concerning my injury and treatment. I understand that I am financially responsible for payment of all services that are not paid for by my insurance carrier. Should my account will be referred for collections, I will be responsible to pay the cost of collection, including legal fees. All checks returned for NSF will subject to a $30 return fee (7/26/22).

Patient/Guardian Signature:_____ **Date:**_____
By typing your name above, you agree that your typed signature can be used as your actual signature.

Medical History

Patient Name:_____ Date of Birth:_____

Height: _____ Weight:_____

Have you ever had these symptoms before? ☐ YES ☐ NO If yes, when? _____

Check those that apply to your current conditions:

Work related		Sports		Fall		Motor Vehicle Accident	
Chronic Conditions		Injury Recurrence		Surgical		Other	

Check if you have, or have had any of the following:

Diabetes If yes, what type_____		Cancer If yes, what type?_____		Heart Disease If yes, what type?_____	
Do you take insulin		Bowel/Bladder Issues		Hypertension	
Hypoglycemia		Seizures		Heart Attacks	
Kidney problems		Arthritis		Pacemaker	
Asthma		AIDS/HIV		Chest Pain	
Headaches		Metal Implants		Currently Pregnant	
Osteoporosis/Osteopenia		Nausea/Vomiting/Dizziness		Fractures	

Is there any other information about your present health we should know about that are not listed above?

_____

Allergies:_____

Please list any medication you are currently taking and dosage: _____

_____

Have you had any recent falls? ☐ Yes ☐ No If yes, please explain:_____

Please list surgical history: _____

Please circle the test you had performed: X- Rays MRI CT Scan Bone Scan Other_____

Activities you want to achieve: Rank 1-10 how difficult they are, 1 being easiest and 10 being hardest:

1. _____ 1 2 3 4 5 6 7 8 9 10
2. _____ 1 2 3 4 5 6 7 8 9 10
3. _____ 1 2 3 4 5 6 7 8 9 10

Patient/Guardian Signature: _____ **Date:** _____

By typing your name above, you agree that your typed signature can be used as your actual signature.

Payment Agreement

Payments are due at the time of service. Due to the frequency of therapy appointments, a payment card MUST be saved on file.

Initial One:

_____ I would like to save my card on file and be charged at time of service

_____ I would like to save my card on file and be charged in lump sum at end of each week

_____I choose not to keep my card on file and understand that I am responsible for paying at the time of service and will be responsible for any outstanding balances that will be billed to me.

Circle one: Amex Visa MC Debit Discover HSA

Credit Card #: _____ Exp Date: _____

CVV:_____ Zip Code: _____

Patient Appointment Reminders:

To maximize your therapy experience and improve office efficiency, we would like to send you appointment reminders. Please check the best method to contact you:

_____ Voice Calls: Phone Number:_____

_____ Text Message: Phone Number: _____

_____ Email:_____

Cancellation/ No Show Policy: We require a **24 hour notice** if you need to cancel an appointment. We charge a **$50 or $100 fee depending on blocks** for any cancellations under 24 hours or if you fail to show up for your scheduled appointment.

By signing this document you are authorizing Michigan Orthopaedic Rehabilitation/Michigan Hand Therapy to charge your card for any copays, deductibles, and/or canceled/missed appointments.

Patient/Guardian Signature_____
By typing your name above, you agree that your typed signature can be used as your actual signature.

Patient Name_____ Date:_____
(Print)