NEW HAMPSHIRE HAND THERAPY CENTER, INC.
80 Palomino Lane, Suite 401
Bedford, NH 03110
(603) 669-7716 / Fax: (603) 669-0103

PATIENT REGISTRATION

PATIENT INFORMATION

Name: ____________________

DOB: ____________________ SS#: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Home Phone: ____________________ Cell#: ____________________ Work#: ____________________

Email for appointment reminders: ____________________

Emergency Contact: ____________________ Relation to patient: __________ Phone: ____________________

INSURANCE INFORMATION

☐ Health Insurance ☐ Medicare ☐ Medicaid ☐ Private Insurance

Is this diagnosis a result of a motor vehicle accident? ☐ YES ☐ NO If yes, inform the office staff immediately.

Insurance Co: ____________________ ID#: ____________________

Insured Name: ____________________ Relation to patient: ____________________

Insured Date of Birth: ____________________

Secondary Insurance Co: ____________________ ID#: ____________________

Insured Name: ____________________ Relation to Patient: ____________________

Insured Date of Birth: ____________________

WORKER'S COMP OR AUTO INSURANCE

☐ Worker's Comp ☐ Auto Insurance

Insurance Co: ____________________ Claim #: ____________________

Billing Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Adjuster/Lawyer: ____________________ Phone: ____________________

Occupation: ____________________ Employer: ____________________

Address: ____________________ City: ____________________ State: __________ Zip: __________

Person/Party responsible for payment: ____________________

REFERRAL INFORMATION

Referring MD: ____________________

PCP: ____________________

Date of injury/surgery: ____________________

Return date to see MD: ____________________

How were you referred to us? (please check)

☐ Physician ☐ Friend/family

Phone Book:

☐ Concord ☐ Manchester ☐ Nashua

Other: ____________________

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the release of information to my doctor and to my insurance company necessary to process this claim.
Initials: ____________

PATIENT PRIVACY POLICY: I acknowledge that a copy of NHHTC patient privacy policy was offered or issued to me. **Initials:** ____________

ASSIGNMENT OF PAYMENT: I assign payment of medical benefits to NH Hand Therapy Center, Inc. for services rendered. **Initials:** ____________

TO OUR MANAGED CARE PATIENTS: Your signature below indicates that if you received any services at NHHTC and the fees are denied because you did not obtain prior approval from your primary care physician, you will be personally responsible for those fees.
Initials: ____________

CANCELLATION POLICY: Appointments cancelled without 24 hours notice will result in a $25.00 charge for which I am *personally* responsible. Three missed appointments without 24 hours notice could result in discharge for non-compliance. **Initials:** ____________

RESPONSIBILITY FOR PAYMENT: I understand that I am responsible for full payment for services rendered. Any charges not covered by my insurance company, including copayments, deductibles, splints, and supplies, will be payable at the time of treatment. I will be responsible for all fees for services rendered that are not covered by insurance. **Initials:** ____________

All balances not paid within thirty (30) days of invoice will bear interest at a rate of one and one-half percent (1½%) per month, or eighteen percent (18%) per annum until paid in full. If I default in making timely payments on my account, I will be responsible for all costs of collection including attorney fees and court costs. Initials: _____________

I hereby request, authorize and consent to medical treatment by New Hampshire Hand Therapy Center, Inc. ("NHHTC"), its employees and agents. I understand and acknowledge that occupational therapy and physical therapy are not exact sciences and that along with potential benefits, there are potential risks associated with the treatment and that no guarantees have been made to me regarding the results of my treatment by NHHTC. **Initials:** _____________

This consent will be valid during the course of my treatment by NHHTC, unless I revoke it.

I have read this form carefully and agree to the above mentioned policies. I have had the opportunity to ask questions about this form and those questions have been answered.

____ ____________________

Signature of Patient/Legal Guardian Date

____ ____________________

Witness Date