Empower Hand Therapy and Rehabilitation, LLC

# Patient Registration Form

## Patient Information

Date: _____

_____

Name (Full Legal Name) Date of Birth

_____

Street Address, City, State, Zip Code Primary Phone Number

_____

Email Address Alternate Phone Number

Reason for seeking care:

| |
|---|
| |

Date of Injury/Surgery: _____ Have you been seen for this condition before? Yes / No

## Billing Information

_____

Responsible Person's Name Date of Birth Relation to Patient

_____

Primary Phone Number Address

## Insurance Information

_____

Primary Company Address

_____

Phone Number ID # Group # Subscriber's Name

_____

Secondary Company Address

_____

Phone Number ID # Group # Subscriber's Name

Accident related to: Work / Auto / Other:_____

_____

Workman's Comp / Auto Ins. Carrier Claim's Address

_____

Phone Number Claim # / Policy # Adjuster

Empower Hand Therapy and Rehabilitation, LLC

## Current Care and Attestation

**Please check one below:**

- I **AM NOT** under the care of a licensed health practitioner for the symptoms listed on this form and I wish to seek occupational therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, licensed nurse practitioner, or licensed physician assistant.)

  *I understand that the current course of occupational therapy care will last no more than 60 consecutive days, and that additional occupational therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional occupational therapy services beyond this 60-day period, I will be required to obtain a referral from a licensed health care practitioner.*

- I **AM** under the care of a licensed health practitioner for the symptoms listed on this form and I wish to seek occupational therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, licensed nurse practitioner, or licensed physician assistant.)

  **Practitioner Information:**

  _____

  Practitioner Name Office Number

  _____

  Street address, City, State, Zip Code Fax Number

  *I understand that the current course of occupational therapy care will last no more than 60 consecutive days, and that additional occupational therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional occupational therapy services beyond this 60-day period, I will be required to obtain a referral from the licensed health care practitioner named above.*

  *I understand that the practitioner named above will be provided a copy of my initial evaluation and patient history within 14 days.* ***I hereby consent to the release of my personal health and treatment records to the practitioner named above.***

**Patient Signature**_____ Date_____