SMHT
SANTA MONICA HAND THERAPY

Welcome to Santa Monica Hand Therapy

We ask that you to read the following information which pertains to our office policies and procedures. It is important that you keep this information and refer to it while you are a patient at this clinic.

Hours of Operation:
Monday - Friday 8:00 am to 5:00 pm.
We are closed for lunch everyday from 1:00 pm to 2:00 pm.

24 Hour Cancellation Policy:
Please give us 24 hours notice if you need to cancel your appointment.
Last minute cancellations and no shows are subject to a $50.00 cancellation fee.

Please be aware of the following information:

1. Our office uses sign in sheet for patients when they arrive.
2. We use a common treatment room where patients and therapists interact.
3. The files are kept unlocked in the treatment and office areas during the day.
4. We may need to leave you a message regarding your appointment at the number you provide to us.
5. We do not allow the use of cellular phones in the treatment area.

Financial Policy:
For financial policy details, please refer to the attached financial policy.

If you have any questions regarding your insurance benefits or need to set up a payment plan, please contact our Billing Manager, Patricio Mejia at (310) 829-3320 x 1.

We strive to give the best care possible and our patients are our highest priority. If you are at all dissatisfied with our services, comment forms and confidential patient satisfaction surveys are available from the front office.

Thank you for choosing Santa Monica Hand Therapy. We look forward to working with you!

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NOTICE OF PATIENT PRIVACY INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN THE ENCLOSED CONSENT FORM.

SANTA MONICA HAND THERAPY'S LEGAL DUTY

Santa Monica Hand Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Santa Monica Hand Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example: Santa Monica Hand Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Santa Monica Hand Therapy may also use or disclose your personal health information without prior authorization for public health purposes, auditing purposes, research studies and emergencies. We also provide information when required by law.

In any other situation, Santa Monica Hand Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Santa Monica Hand Therapy may change its policy at any time. When changes are made, Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Santa Monica Hand Therapy will consider all requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Santa Monica Hand Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the practice owner:

Maria Zecchetto
Santa Monica Hand Therapy
2001 Wilshire Blvd Suite 310
Santa Monica, CA 90403
Telephone (310) 829-3320 Fax (310) 829-3305

You may also send a written complaint to the U.S. Department of Health and Human Services.

PATIENT INFORMATION SHEET
(PLEASE PRINT)

☐ Ms.
☐ Mrs.
NAME: ☐ Mr. ____
Last | First | Middle Intitial

SOCIAL SECURITY NUMBER: ________-________-________ BIRTHDATE: _____/_____/_____

HOME ADDRESS: ______________________________________ AGE: ________

CITY: __________________ STATE: ____________ ZIP CODE: ____________________

HOME PHONE: (   ) __________________ CELL PHONE: (   ) __________________

BILLING ADDRESS: ____
(IF OTHER THAN HOME ADDRESS)

DATE OF ONSET/DATE OF INJURY: ______________ EMAIL ADDRESS: ______________

WORK PHONE: (   ) ______________

EMERGENCY CONTACT: __________________________ PHONE: __________________

WHO REFERRED YOU THIS OFFICE: ______________________________________

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY (PRIMARY): ______________________________

NAME OF SECONDARY INSURANCE: ______________________________________

NAME OF SUBSCRIBER (IF OTHER THAN SELF): ___________________________

RELATIONSHIP TO PATIENT: __________________ BIRTHDATE: _____/_____/_____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: ________-________-________

PATIENT INFORMATION CONSENT

I have read and fully understand Santa Monica Hand Therapy's Notice of Information Practices. I understand that Santa Monica Hand Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and for any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Santa Monica Hand Therapy will consider requests for restriction of personal health information on a case-by-case basis, but is not obligated to agree to your request.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Santa Monica Hand Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____
Patient Name

______________________________ ______________
Signature Date

MEDICAL HISTORY

PATIENT NAME____

Please indicate whether you have had any of the following conditions:

Condition		
Heart disease or heart attack	No	Yes
Rheumatic fever	No	Yes
High blood pressure	No	Yes
Stroke	No	Yes
Epilepsy or convulsions	No	Yes
Kidney or bladder problems	No	Yes
Diabetes	No	Yes
Tumor or cancer	No	Yes
Respiratory disease	No	Yes
Pneumonia or emphysema	No	Yes
Tuberculosis	No	Yes
Asthma	No	Yes
Hepatitis	No	Yes
Peptic ulcer or pancreatitis	No	Yes
Anemia/Blood disorder	No	Yes
Bleeding disorders	No	Yes
Jaundice	No	Yes
Hernia	No	Yes
Thyroid disorder	No	Yes

Other____

____

Headache history? Type: Frequency:

Question		
Are you now pregnant?	No	Yes
Do you have a Pacemaker?	No	Yes
Do you have any surgical implants?	No	Yes
Do you have hearing/vision loss?	No	Yes

Surgery: Please list operations you have had in the last year:

____

Medications:

Name	Dosage	Frequency	Oral or Injection	Purpose

Allergies: Please list any allergies you may have:

____

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SMHT FINANCIAL POLICY

Please read and sign the statement prior to initiating any treatment.

Thank you for choosing Santa Monica Hand Therapy as your hand therapy provider. We are committed to your treatment being successful. The following is our financial policy.

1. All patients must complete the information sheet.
2. **Patients are responsible for contacting their insurance company and verifying their insurance benefits including policy deductibles, co-payments, co-insurance amounts, visit limitations and any pre-authorization requirements**. As a courtesy to you, we will also verify your coverage, but will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, you are ultimately responsible for knowledge of your insurance benefits and for the full payment of your bill.
3. Co-payments or co-insurance payments are due each visit.
4. If you do not have insurance, full payment is due at the time of service.
5. We accept cash, checks and most credit cards.

We bill insurance companies as a courtesy to our patients. However, you are ultimately responsible for co-payments, co-insurance amounts or any part of the bill that is not paid by your insurance company. **In trying to reduce their own costs, some insurance companies have recently developed a policy of unilaterally declaring "medical necessity has not been established" for portions of treatment. In this case, you are still responsible for the services that were rendered.**

In order for us to bill your insurance, you must provide us with the following documents:

1. A current physician's prescription ordering therapy and including a diagnosis, as well as frequency and duration of treatment, updated as necessary.
2. A copy of your insurance card.

Please be advised that this clinic will require payment in full for treatments rendered if these documents are not provided. If your insurance company fails to reimburse us within 45 days, you will be responsible for the entire unpaid balance. It is also your responsibility to check with your insurance company regarding the status of your claim.

Depending upon your insurance plan, you may be required to pay a co-payment (fixed dollar amount) or a co-insurance (percentage of the charge per visit) for services rendered. Since we will not be able to ascertain the exact dollar amount of a co-insurance payment in advance, we will estimate the amount and collect it at each visit. Once we have received payment from the insurance company, we will bill you for any amount not covered, or issue a refund check to you if over-payment is determined. Payment is expected within 15 days of the date of the statement.

2001 Wilshire Blvd. Suite 310 Santa Monica, California 90403 telephone 310.829.3320 facsimile 310.829.3305

A charge of $50.00 will be billed for any missed appointment without 24 hours notice.

Please let us know if we can help you with any of the above information.

I understand that I am fully and completely responsible for the knowledge of my policy's benefits and limits, including number of visits, deductible amount, requirement of pre-authorization (when indicated) and co-insurance or co-payment amounts.

By my signing below, I recognize and accept that I am ultimately financially responsible for all charges for services rendered including, but not limited to, any services of fees denied or not covered by my insurance company.

I, _________________________ certify that I have read and fully understand all of the above information.

Name

____________________________________ ____________________

Signature of patient or responsible party Date