HelpingHandsTherapyCenter
WHERE NY'S TOP DOCTORS SEND THEIR PATIENTS

Specializing in Upper Extremity Rehabilitation
7610 13th Avenue • Brooklyn, NY 11228
Tel: 718-234-5091 • Fax: 718-234-5093
www.helpinghandstherapycenter.com

Michael Argiro MS, OTR/L, CHT
Certified Hand Therapist

NEW PATIENT PROFILE

Patients Name: _____ Age: _____ Gender: M or F

Social Security #: _____ Date of Birth: _____/_____/_____

Address: _____ City:_____ State:_____Zip Code:_____

Home Phone (_____)-_____-_____Cell Phone: (_____)-_____-_____ Work Phone: (_____)-_____-_____

Email: _____ (to receive notifications about appointments)

Emergency Contact Name: _____ Phone #: (_____)-_____-_____

Who can we thank for referring you? _____

Have you had any Occupational Therapy (OT) or Physical Therapy (PT) this calendar year? Yes or No

If yes, how many visits? : _____ Which therapy service ? PT or OT ? (circle which)

INSURANCE

Policy Holder: _____ Date of Birth: (_____)-_____-_____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

REFERRING DOCTOR INFORMATION

Doctor: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____)-_____-_____ Date of Prescription: _____/_____/_____

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CONSENT FOR TREATMENT

Patient's Name _____

Street Address _____

City _____ State _____ Zip Code _____ Phone _____

Primary Insurance _____ Insurance ID # _____

Secondary Insurance _____ Insurance ID # _____

1. I hereby confirm that the necessity for medical treatment has been explained to me, and I authorize the medical staff, employees, and contracted health care providers at 7610 13th Avenue, Brooklyn, NY, 11228 to provide necessary medical treatment to me, including diagnostic procedures and medical care.

2. I assign to Helping Hands Therapy Center all of my rights, title and interest to medical and/or automobile insurance benefits and all other rights and benefits otherwise payable to Helping Hands Therapy Center for those services provided at 7610 13th Avenue, Brooklyn, NY, 11228.

3. I understand that Helping Hands Therapy Center cannot provide continuous security to my personal property (money, jewelry, eyeglasses, etc.) The employees of this facility are not responsible for loss or damage of my valuables, unless it was given for safekeeping.

4. I authorize Helping Hands Therapy Center to release my medical record information to any physicians or caregiver participating in my care while I am being treated at the facility, and to any physician or caregiver involved in my follow-up care.

_____ _____

Patient Signature Date

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LIMITATION OF LIABILITY – Certain insurances will only pay for services which they deem necessary. It is my understanding that it is the practice of the office to perform tests which are deemed necessary and sufficient for the diagnosis of my condition. In the unlikely event that my insurance company fails to pay either myself or this office for any of these necessary services, I agree to be financially responsible for payment.

Furthermore, I agree to be financially responsible for any and all applicable deductibles and co-insurance payments.

RELEASE OF INFORMATION - I permit this office to disclose all or part of this patient's medical record to any person, corporation, or this agency when required for the collection of benefits or upon request by a referring physician.

ASSIGNMENT OF BENEFITS - I authorize payments of these services by all benefits directly to this office.

I confirm that I have read and fully understand the above.

Patient (or Guardian) Signature _____ **Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge that you are aware of the Notice of Privacy.

Patient (or Guardian) Signature _____ **Date**_____

FOR OFFICE USE ONLY

- ☐ Patient refused to sign
- ☐ Due to emergency situation it was not possible to obtain an acknowledgment.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (specify) _____ Initials _____