Hands Up Occupational Therapy

Your Hands are in Good Hands.

Patient Registration

First Name, Middle Initial:	**Last Name:**	**SSN:**
Date of Birth:	**Gender:**	**Marital Status:**
Street Address:	**City:**	**Zip Code:**
Home Phone:	**Cell Phone:**	**Email Address:**
Referring Doctor:	**Next Doctor Appt:**	**Date of Surgery *(if applicable):***

How did you hear about Hands Up Occupational Therapy? _____

Have you had Occupational Therapy this calendar year? _____

Are you currently on a program for any other therapy? _____

Patient Signature: _____Date: _____

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Patient Attendance Policy Agreement

Hands Up Occupational Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient to minimize waiting times and assure continuity of your individualized treatment session.

Cancellations, especially within 24 hours, along with no-shows, decrease our ability to accommodate scheduling needs of other patients. Therefore, we ask for your full cooperation with the following cancellation policy

- If you are unable to keep a scheduled appointment, we request you notify our office 24 hours prior to your scheduled appointment time. If someone is not available to take your call, please leave a voice or text message on our office phone at (917) 855-7085.
- All cancellations and no-shows will be documented in our medical records and appropriately reported to your physician and insurance/third party payer
- **If you do not honor a scheduled appointment time either by late cancellation or no show, you will be charged a $100 cancellation fee.**

We believe this policy is necessary for the benefits of all patients so we can continue to provide high quality treatment and services to all patients at Hands Up Occupational Therapy. We appreciate your cooperation and adherence to this policy.

Patient Signature: _____Date: _____

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Social Media Informed Consent

Hands Up Occupational Therapy has expanded the practice by utilizing social media platforms, including HUOT site, Facebook, Instagram, and the web, to educate and inform current and future occupational therapists, healthcare professionals and individuals to learn more about treatment of various diagnoses within occupational therapy. Please select one of the following options of your participation in our social media platform:

- **I do provide consent** to Hands Up Occupational Therapy to take photographs and videos for the purpose of posting on social media platforms including the company site, Facebook, Instagram, and the web.

- **I do not provide consent** to Hands Up Occupational Therapy to take photographs and videos for the purpose of posting on social media platforms including the company site, Facebook, Instagram, and the web.

Patient Signature: _____Date: _____

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E-mail Medical Communication Informed Consent

I acknowledge that by engaging in electronic communication, I am aware that the confidentiality of personal medical information may be compromised due to the inherent risks associated with electronic exchanges. Compared to face-to-face information exchange, electronic communication carries a higher probability of confidentiality breach. Therefore, it is advisable to limit the use of electronic communication/text messages for personal medical matters. Please also note that there is no guarantee of timely receipt or responsiveness to emails. To mitigate potential risks, it is recommended to refrain from discussing sensitive medical matters through email or texting, as a breach could have adverse consequences for the patient and their representatives.

By providing my signature, I confirm that I have read and understood the content and policy of my healthcare provider. I agree to adhere to the principles and guidelines outlined in this document. I also acknowledge the risks and limitations associated with the transmission of medical information electronically. Therefore, I release my healthcare provider from any liability arising from any unauthorized disclosure or inadvertent leakage of such information to parties outside the intended recipients. I understand that the practice and/or provider at HUOT will not be held responsible for any delays in receiving such communications and/or any resulting harm from such delays.

Patient Signature: _____Date: _____

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Credit Card Authorization Form

Please complete all fields for us to securely store your credit card information on file for future transactions. You may cancel this authorization at any time by contacting our office at (917) 855-7085 or by email info@handsupot.com. This authorization will remain in effect until canceled.

Thank you.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Patient Signature: _____Date:_____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of the legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the practice.

Who will follow this Notice:
Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You:
The following categories describe different ways that we may use and disclose medical information about your specific consent or authorization, Examples provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment:
We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medication, we prescribe for the treatment process.

For Payment:
We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance party or a third party. Example: We may need to send protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations:
We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures that can be made Without Consent or Authorization:
- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities and providers payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public Health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.