

# STRAIT OCCUPATIONAL & HAND THERAPY, P.S.

Lynda Guditus Williamson, OTR/L, CHT, CEAS, PBP

Occupational Therapist, Certified Hand Therapist, Certified Ergonomics Assessment Specialist, Professional Bowenwork Practitioner

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Referral Source: \_\_\_\_\_

Have you had a complete physical examination within the last year? \_\_\_\_ YES \_\_\_\_ NO

Have you had or do you currently have a contagious disease? \_\_\_\_ YES \_\_\_\_ NO

If yes, please specify \_\_\_\_\_

PLEASE CHECK ALL THAT APPLY BELOW IF YOU HAVE **RECENTLY** HAD ANY OF THE FOLLOWING COMPLAINTS

- |  |   |
|--|---|
| <input type="checkbox"/> Shortness of breath                   | <input type="checkbox"/> High/low blood pressure              |
| <input type="checkbox"/> Seizure/Epilepsy                      | <input type="checkbox"/> Changes in hearing                   |
| <input type="checkbox"/> Pulsating pain anywhere in your body  | <input type="checkbox"/> Frequent or severe headaches         |
| <input type="checkbox"/> Constant and severe pain in lower leg | <input type="checkbox"/> Problems w/swallowing                |
| <input type="checkbox"/> Discolored or painful feet            | <input type="checkbox"/> Changes in vision (blurred or loss)  |
| <input type="checkbox"/> Dizziness                             | <input type="checkbox"/> Problem with balance or falling      |
| <input type="checkbox"/> Persistent pain at night              | <input type="checkbox"/> Problems with coordination           |
| <input type="checkbox"/> Swelling                              | <input type="checkbox"/> Fainting spells                      |
| <input type="checkbox"/> Constant pain anywhere in your body   | <input type="checkbox"/> Sudden weakness                      |
| <input type="checkbox"/> Unexplained weight loss in 2 weeks    | <input type="checkbox"/> Fever/night sweats                   |
| <input type="checkbox"/> Loss of appetite                      | <input type="checkbox"/> Recent severe emotional disturbances |
| <input type="checkbox"/> Unusual lumps or growths              | <input type="checkbox"/> Swelling or redness in any joints    |
| <input type="checkbox"/> Fatigue                               | <input type="checkbox"/> Pregnant                             |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Stroke                               |
| <input type="checkbox"/> Frequent or severe abdominal pain     | <input type="checkbox"/> HIV                                  |
| <input type="checkbox"/> Frequent heartburn or indigestion     | <input type="checkbox"/> Pain or heaviness in your chest      |
| <input type="checkbox"/> Frequent nausea and vomiting          | <input type="checkbox"/> Surgery                              |
| <input type="checkbox"/> Change or problems with bladder       | <input type="checkbox"/> Broken bones                         |
| <input type="checkbox"/> Change or problem bowel function      | <input type="checkbox"/> Cancer                               |
| <input type="checkbox"/> Unusual menstrual irregularities      | <input type="checkbox"/> Feel downhearted or worthless        |
| <input type="checkbox"/> Use tobacco                           | <input type="checkbox"/> Feel unsafe where you live           |
| <input type="checkbox"/> Fallen twice in the past year         | <input type="checkbox"/> Injured from a fall in the past year |

ARE YOU CURRENTLY TAKING MEDICATION? \_\_\_\_ Yes \_\_\_\_ No

(if yes please list below or include an additional page)

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# **Strait Occupational & Hand Therapy appreciates the opportunity to serve you. We pledge to provide you with the very best rehabilitation services.**

## **LATE CANCELLATIONS AND NO SHOWS**

\_\_\_\_\_ initial

Cancellations or schedule changes must be made by 12:00 noon the day prior to your scheduled appointment or a charge of \$50.00 will be assessed. Patients are responsible for paying this fee at the time of their next appointment. SOHT collects these fees based on Medicare/Medicaid guidelines, outlined in Pub 100-04 Medicare Claims Processing; Centers for Medicare & Medicaid Services; Transmittal 1279. If a patient fails to show for two (2) scheduled appointments or cancels an excessive number of times, occupational therapy will be discontinued and their physician will be notified.

## **TIMELINESS**

\_\_\_\_\_ initial

We value your time and don't want to keep you waiting. Occasionally, we are delayed by an unexpected event with another patient, but please be assured that the quality of your treatment will not suffer. If you arrive late, your treatment will end at its scheduled time in order to not keep the next person waiting.

## **FINANCIAL POLICY**

\_\_\_\_\_ initial

As a courtesy, we will bill the primary insurance company for our patients if we are provided with the necessary information. Secondary insurance plans will be billed upon request. Your insurance coverage is a contract between you and/or your employer, and the insurance company. Therefore, it is the **patient's responsibility** to determine occupational therapy benefits, authorizations, referrals, co-pays, etc. It is also the **patient's responsibility** to follow up with their insurance company on all unpaid visits. If it is necessary to set up a payment plan, please contact our office at 360-417-0703. Questions regarding billing should be directed to Marci Pohle at (509) 443-4630. Unpaid medical bills can adversely affect your credit score. Payment of **co-pay, co-insurance, and outstanding patient balances will be collected at time of check-in**. Please be prepared and have payment method ready. We accept cash, check, credit cards, and money orders. Balances 90 days or longer past due will be accessed 5% interest on the outstanding balance, and may be subject to collections.

## **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

\_\_\_\_\_ initial

I authorize Strait Occupational & Hand Therapy to release any necessary medical information such as diagnosis, test results, photographs, records, and/or reports requested by my insurance carrier, Primary Care Provider, or Referring Physician. We follow HIPAA guidelines for release of medical records.

## **PATIENT CONSENT**

I hereby consent to treatment by the occupational therapist. I acknowledge that I have read and understand the financial policy and the cancel/no show policy stated above.

\_\_\_\_\_  
**Patient's signature (If patient is a minor, Parent/Guardian signature)**

\_\_\_\_\_  
**Date**



Name \_\_\_\_\_

Date \_\_\_\_\_

## Health and Activities of Daily Living

The following questions are about general physical activities you might do during a typical day. How able are you to accomplish these activities?

Activity	Easily	With Difficulty	Not at all
1. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
2. Moderate activities, such as moving a table, pushing a vacuum cleaner	1	2	3
3. Lifting or carrying groceries	1	2	3
4. Climbing several flights of stairs	1	2	3
5. Climbing one flight of stairs	1	2	3
6. Bending, kneeling, or stooping	1	2	3
7. Walking more than a mile	1	2	3
8. Walking several blocks	1	2	3
9. Walking one block	1	2	3
10. Bathing and dressing yourself	1	2	3
11. Sitting	1	2	3
12. Standing	1	2	3

### Bathing

Do you need a cast protector?	Yes	No
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Can you manage?	Easily	With Difficulty	Not at All
Clipping finger or toes nails			
Turning faucets on/off tub and sink			
Using razor			
Washing hands			
Washing feet			
Washing back			
Washing underarms			
Brushing teeth			
Shaving			
Combing or brushing hair			

<b>Dressing, Can you manage?</b>	<b>Easily</b>	<b>With Difficulty</b>	<b>Not at All</b>
Zippers			
Buttons			
Hook and Eye			
Belts and Buckles			
Snaps			
Bras			
Putting on and tying shoes			
Putting on socks			
Putting on splints/braces			

<b>Food Preparation, Can you manage?</b>	<b>Easily</b>	<b>With Difficulty</b>	<b>Not at All</b>
Opening jars, cans, bottles			
Peeling or slicing			
Opening packages			
Lifting pots and pans			

<b>Eating, Can you manage?</b>	<b>Easily</b>	<b>With Difficulty</b>	<b>Not at All</b>
Using a spoon or fork			
Drinking from a cup or glass			
Cutting food			
<b>Household, Can you manage?</b>	<b>Easily</b>	<b>With Difficulty</b>	<b>Not at All</b>
Laundry			
Vacuuming			
Washing dishes			
Reaching shelves at head level			

<b>Other, Can you manage?</b>	<b>Easily</b>	<b>With Difficulty</b>	<b>Not at All</b>
Using scissors			
Managing medicine bottles			
Opening doors with knobs			
Handling coins			
Holding a book			
Writing			
Using a telephone			

<b>Office Use Only</b>	<b>(# X 4.2)</b>	<b>(# X 2.08)</b>	<b>(# X 0)</b>	<b>Total</b>

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## Acknowledgement of Receipt of Privacy Practices

Strait Occupational & Hand Therapy  
Office Manager (360) 417-0703

We must make a good faith effort to obtain a written acknowledgement that we gave you a copy of our Notice of Privacy Practices no than the date of the first service delivery. If we are unable to obtain your acknowledgement we must document why.

If there is an emergency, providing our Notice of Privacy Practices may be delayed until reasonably practicable after the emergency situation is resolved.

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notices of Privacy Practices.

by email at \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- Parent or Guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

For Office Use Only:

Signed form received by \_\_\_\_\_ Date \_\_\_\_\_

Acknowledgement refused:

Efforts to obtain: \_\_\_\_\_

Reason for refusal (circle one): Patient refused. Patient did not follow instructions Didn't mail back form  
Incapacity (circle one): Medical Literacy Emergency Other \_\_\_\_\_

C:\Documents and Settings\Any User\Front Office\NewPatientForms\Receipt of Privacy Practices.doc

