Acknowledgements

Name:		Best Contact Phone#:
Your Employer		Work Phone#
Your Social Security # or Driver's License #		
Emergency Contact Name	Relationship	Contact Phone #'s

My Health Information

I understand that information about my medical history and current condition is shared among parties including Pinnacle, the physician who referred me, and my insurance company. I understand that this information is necessary for coordinating my health care, billing and payments, and administrative operations and that it may include medical photographs. I also understand that Pinnacle will work to protect my privacy and the confidentiality of my personal health information

Initials _____

My Appointment Schedule

I understand that attending scheduled appointments is critical and will involve my recovery. Missing or delaying treatment may reduce the benefits of therapy. If you feel you will not make a scheduled appointment you are responsible for contacting us 24 hours before your scheduled time. No call (24hr) / no show missed appointment fee of $50.00 maybe charged to you before you can reschedule. Initials _____

Medicare Patients Only

I will inform Pinnacle Hand Therapy of any type of Home Health Care Services I receive. If I do not, I will be financially responsible for the balance not paid by Medicare due to Medicare's consolidated billing policy.

Are you currently receiving Home Health Services? Yes / No If yes which agency? _____

Phone#_____ **Initials_____**

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Pinnacle Hand Therapy for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company.

Signature: _____ Date: _____