DASH Therapy

Initial Evaluation – Pre-Exam Questionnaire

CONFIDENTIAL

DASH THERAPY
Disorders of the Arm, Shoulder & Hand

In order to evaluate your condition fully, please be as accurate as possible.

Name: Last _____ First _____ M.I ____

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

Date of Birth: _____ **Age:** _____ **Home Phone#:** _____

Gender: Female Male **Cell Phone#:** _____

Social Security# : _____

Marital Status: M S W D **Other:** **E-mail Address:** _____

Ocupation:

Employer: _____ **Phone#:** _____

Emergency Contact: Name: _____ Phone#: _____ **Relationship** _____

Referring Doctor : _____ **Primary Doctor:** _____

Primary Complaint: _____

INSURANCE INFORMATION

Primary Insurance Company

Insurance Name: _____ **Phone:** _____

Name of Primary Subscriber : _____ **DOB:** _____

Subscriber ID# _____ **Group#** _____

Secondary Insurance Company

Insurance Name: _____ **Phone:** _____

Name of Primary Subscriber : _____ **DOB:** _____

Subscriber ID# _____ **Group#** _____

MEDICARE PATIENTS ONLY

Have you been in a skilled nursing facility within the last 30 days? YES NO

Name of Facility: _____ **Phone:**

UPDATED INFORMATION

Change of Address: _____ **Phone:** _____

_____

Employer: _____

Other Insurance Company

Insurance Name: _____ **Phone:**

Name of Primary Subscriber : _____ **DOB:**

Subscriber ID# _____ **Group#** _____

Summary Notice of Privacy Practices

INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The law requires that we maintain the privacy of your medical information. You must be given a copy of this notice. We must abide by the terms of this notice. If the notice is revised, a copy will be available upon request.

We use and disclose your medical information for **Treatment**. For example, we will call your doctor to discuss the progress that you have made as a result of your therapy treatments. We will use and disclose your medical information for **Payment**. For example, we may provide your insurance plan with information about your diagnosis and treatment. We will use and disclose your medical information for **Health Care Operations**. For example, we may use your medical information to evaluate and/or improve our services. We may contact you by phone or mail to remind you of an appointment, to discuss other health care matters or to discuss payment for our services.

We may use and disclose your medical information to notify you of treatment alternatives or other health related benefits and services. We may disclose your medical information to those individuals who are involved in your care or payment for that care. You must notify our office in writing if you do not want us to make these communications.

We may use your medical information as required or permitted by law. Any other uses and disclosures will be made only upon your written authorization. You can revoke and authorization at any time by notifying our office in writing.

You have the following rights: **to receive a copy of your privacy notice; to request restrictions on the used and disclosures of your medical information and to receive confidential communications; to inspect and copy your medical information; to request an amendment to your medical information; and to an accounting of disclosures of your medical information.**

Contact Information: If you believe that your privacy rights have been violated, please contact our Designee at (559) 627-3274 or the U.S. Secretary of Health and Human Services.

I hereby acknowledge my receipt and understanding of the ***NOTICE OF PRIVACY PRACTICES***.

IMPORTANT NOTICE

I agree to pay $25.00 fee if I NO SHOW or CANCEL an appointment with less than a 24-hour notice. _____

Initials

All services rendered are charged directly to patients. Patients are financially responsible for payments unless other arrangement have been made. Payment is due at time of service. I hereby authorize DASH THERAPY treatment and release of billing information necessary to process my claims for payment, and be payable to them. In no way whatsoever will I revoke the assignment / authorization without first obtaining written consent from DASH THERAPY this assignment / authorization shall be as valid as my insurance form. A photocopy of this assignment shall be as valid as the original.

Patient Signature: _____ **Date:** _____

Responsible Party (If Minor) : _____ **Date:** _____

PARENT/GUARDIAN PHOTO CONSENT FORM

Date _____

I give permission for **DASH THERAPY** to take a picture of my son/daughter for their records.

Note: These photos are confidential and only available to Dash Therapy staff.

Name of patient: _____ DOB _____

Name of parent/guardian: _____

Parent/guardian signature: _____

DASH THERAPY

Disorders of the Arm, Shoulder & Hand

No Show/Cancellation Policy effective November 1, 2018

Thank you for trusting your medical care to DASH Therapy. When you schedule an appointment with DASH Therapy we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office no later than 24 hours prior to your appointment.

Established Patients:

Any established patient who fails to show cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a "No Show" and charged a $25.00 fee.

The fee is charged to the patient, ***not*** the insurance company, and is due at the time of the patient's next office visit. The patient will not be seen for any subsequent appointments unless this fee is paid prior to your next appointment.

New Patients/Initial Evaluations:

Any new patient who fails to show for his or her initial visit will only be rescheduled if the $25 fee for No Show or Cancellation without 24 hours' notice is paid *PRIOR* to rescheduling. This fee can be paid over the phone with a debit or credit card or in person, when rescheduling.

As a courtesy, when time allows, we make reminder calls, emails, or texts for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Front Office to explain the situation, or you may leave a message 24 hours a day, 7 days a week at the number below.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature of patient, parent/Legal Guardian **Relation to Patient**

_____ _____

Print Name **Date**

2208 W. Sunnyside Ave Suite A/ Visalia, CA 93277 / Phone (559) 627-3274 / Fax (559) 627-3284

Quick DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc...)	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

Place Label Here

$$\text{Quick DASH DISABILITY/SYMPTOM SCORE} = \left[\frac{(\text{sum of } n \text{ responses})}{n} - 1\right] \times 25,$$

where n is equal to the number of completed responses.

A Quick DASH score may <u>not</u> be calculated if there is greater than 1 missing item.