Hand And Rock-climbing Therapeutic Network, LLC
889 N Logan Street Suite 102 | Denver, CO | 80203
(973) 856- 2661 | handsHARTnett@gmail.com

Consent to Treat and Authorization to Release Information, Assignment of Benefits, Financial Responsibility, Self-Pay

Please Initial:

_____ TREATMENT CONSENT: I hereby authorize Hand And Rock-climbing Therapeutic Network, LLC (hereby referred to as HARTnett, LLC) through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my therapist, Dr. Emily Hartnett CHT, in the treatment of my condition.

_____ AUTHORIZATION TO RELEASE INFORMATION: I authorize HARTnett, LLC to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text message. I acknowledge that HARTnett is released from all legal liability that may arise from release of my medical records.

_____ ASSIGNMENT OF BENEFITS: I agree to assign my therapy benefits to HARTnett, LLC and authorize my insurance carrier to make payments to HARTnett, LLC on my behalf. It is my responsibility to inform the facility of changes to my insurance, name, address and phone number.

_____ FINANCIAL RESPONSIBILITY: I understand that I am responsible for payment of my account and I do hereby guarantee payment in full on my account with HARTnett, LLC for treatment and services rendered. HARTnett, LLC does not take responsibility for negotiating settlement of disputed claims. I understand that all copayments, deductibles, and/or coinsurance is to be paid at time of service. All balances that accrue after insurance payment is received is due upon receipt. If the account is referred to an attorney for collections, the undersigned agrees to pay all attorney fees, court costs, legal and lawful collection costs in addition to all other sums due.

_____ ASSIGNMENTS AND AUTHORIZATION TO BILL MEDICARE: If I am a patient covered under Medicare/Medicaid program, I understand that I am responsible for 20% of Medicare Part B services. I hereby assign and authorize payment to be made directly to HARTnett, LLC herein not to exceed the facilities regular charges for this treatment.

_____ SELF PAY: I understand that if my health insurance is not accepted at this time (refer to date below) that I am responsible for the cash pay price of $100 each thirty minute visit, plus the cost of supplies if/ as needed. Supply cost sheet available upon request.

HARTnett, LLC reserves the right to seek reimbursement from all your insurers regardless if you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administrative and copying fee paid to HARTnett, LLC before they are released, regardless of requestor. HARTnett, LLC is HIPAA compliant in regard to information sharing polices.

By signing this document, I acknowledge that I have read, understand, and agree that the information contained in this document including insurance benefits and any additional information I have presented to verify my own identity including my state issued driver's license, state issued photo identification, or my passport, and if applicable, any information used to verify the identity of a minor beneficiary is current, correct, and complete to the best of my knowledge. I agree to the financial terms stated above.

X_____ **X**_____

Signature of Patient or Responsible Party **Date**

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HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under

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the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Upon completion of reading please check the following box.

☐ **I _____ (print) have read and received this HIPAA document on _____ (date).**

X_____ **X_____**
Signature of Patient or Responsible Party **Date**

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Demographic and Insurance Information

Patient Name: _____ Date of Birth: ___/___/___

SSN: _____ Gender: _____ Pronouns: _____

Marital Status: _ Single _ Married _Widowed _Divorced Ethnicity: _____

E-mail address: _____ Phone: _____

Primary Care Physician: _____

Referring Physician *(if applicable, if not referred here by a physician please write "direct access"*: _____

Home address: _____ City:_____

State: _____ Zip: _____

Employment status: _____

Employer *(if applicable):* _____

Emergency contact name: _____

Relationship: _____ Emergency contact phone: _____

Circle 1 or 2: 1. using my health insurance 2. self- pay ($100/visit)

Primary insurance company *(only need to fill out if you are using your insurance)*: _____

Group#: _____ Copay: _____ Phone#: _____

Address: _____ City & State: _____ Zip: _____

Subscriber Name: _____ Responsible Party: _____

Relationship: _____ Date of Birth: _____ SSN: _____

Address: _____ City & State: _____ Zip: _____

Phone number: _____

Secondary insurance company *(only need to fill out if you are using your insurance)*: _____

Group#: _____ Copay: _____ Phone#: _____

Address: _____ City & State: _____ Zip: _____

Subscriber Name: _____ Responsible Party: _____

Relationship: _____ Date of Birth: _____ SS#_____

Address: _____ City & State: _____ Zip: _____

Phone number: _____

X_____ X_____

Signature of Patient or Responsible Party **Date**

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Payment Policy

Thank you for choosing HARTnett LLC for your hand therapy. Please read below, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon request. A non-signed copy can be found on HART-nett.com under Billing. Please initial next to either self- pay or insurance

_____ Self-Pay: If you are without insurance coverage or are not insured by a plan we do business with, your payment in full is expected at each visit. The self pay price is $100 a visit plus the cost of supplies if/ as needed. You will be told the cost of supplies before any supplies (ie custom splints, pre-fabricated splints, scar pads, etc.) are issued to you. Supply cost sheet available upon request. This option is discounted for our uninsured clients and therefore a super bill is not guaranteed.

_____ Insurance: We are currently pending contracts with most Colorado commercial insurance companies, including (as of 11/15/23) Anthem BCBS. Our goal is to notify you as soon as these contracts are complete. At this time, Medicare, Medicaid, MedRisk, Cigna, United Health Care, and Aetna are the only insurances being accepted by HARTnett, LLC. It is your responsibility to know your co-pay and out of pocket costs. Patients are required to present proof of insurance and a valid driver's license at the time of initial evaluation at this time. Change of insurance notification is required within ten days of most recent appointment or you will be responsible for the self-pay rate of $100 plus supplies.

> _____ Super-bills for out of network insurances. Reimbursement is not guaranteed. Pricing per unit is available upon request. Unit price does vary; your practitioner, Emily, will use her clinical judgement and expertise to treat your diagnosis and thus will not entertain client requests of billing codes and unit quantities. Super-bills must be billed per unit and thus the discounted self- pay rate of $100 does not apply. If you choose this option you must pay HARTnett LLC on day of service, be handed a Super- Bill by your practitioner, Emily, and submit this Super- Bill to your insurance on your own time. HARTnett LLC is not responsible if your Super-Bill is not reimbursed. HARTnett LLC suggests you call the number on your insurance card and obtain relevant information regarding Super- Bill reimbursement before selecting this option.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, our facility will only be able to treat you on an emergency basis.

Missed Appointments: Our policy is to charge for missed appointments not canceled within a reasonable amount of time (24 hours prior). These charges will be your responsibility and billed directly to you. All offenses will be charged at a rate of 50% of you appointment (thus $50) as a different patient could have been seen during your allotted time, had notice been give. Please help us to serve you better by keeping your regularly scheduled appointment.

☐ I have read and understand the payment policy and agree to abide by its guidelines.

I _____ (print) have reviewed this payment policy on _____ (date).

X_____ X_____
Signature of Patient or Responsible Party Date

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Medical History Form

Patient Name: _____ Date: _____

Information about current problem:

1. Is this injury related to? __Work __Car Accident __Other Liability/potential Lawsuit __ Not Applicable
2. Do you have Primary Care Physician/Family Doctor __ Yes __NO
   If YES, please provide a date of last appointment _____
3. Race/Ethnicity (please select one)
   __ (Caucasian) White __ Hispanic __ Not Hispanic __ Asian
   __African American __ Native American __Other

If you are a Medicare beneficiary, you are required by Medicare to answer the following questions:

4. Do you consume more than 7 alcoholic drinks in a week __ YES __NO

Mark One Box for each item	NO	YES Under a year	YES, Over a year	mark one box for each item	NO	YES, under a year	YES Over a year
Heart Condition	☐	☐	☐	Sexual dysfunction	☐	☐	☐
High Blood Pressure	☐	☐	☐	Bladder/bowel problems	☐	☐	☐
Circulation/vascular problems	☐	☐	☐	Seizures	☐	☐	☐
Blood Clot/DVT	☐	☐	☐	Head injury	☐	☐	☐
Stroke	☐	☐	☐	Obesity	☐	☐	☐
Chest Pain	☐	☐	☐	Fever/nausea	☐	☐	☐
Kidney Condition	☐	☐	☐	Groin Numbness	☐	☐	☐
Diabetes	☐	☐	☐	Osteoporosis	☐	☐	☐
Smoking	☐	☐	☐	Arthritis	☐	☐	☐
Breathing Difficulties/Asthma	☐	☐	☐	Fractures	☐	☐	☐
Cancer	☐	☐	☐	Infection	☐	☐	☐
Difficulty swallowing	☐	☐	☐	Chronic pain/fibro/headaches	☐	☐	☐
Metal implants	☐	☐	☐	Psychological condition	☐	☐	☐
Pacemaker	☐	☐	☐	Dizziness/Faintness	☐	☐	☐
Peripheral Neuropathy	☐	☐	☐	Ringing in ears	☐	☐	☐
Unexplained weight loss	☐	☐	☐	Allergy to latex	☐	☐	☐
Double vision	☐	☐	☐	Other allergy	☐	☐	☐
Night sweats/night pain	☐	☐	☐	Are you pregnant?	☐	☐	☐

Condition	NO	YES	If YES, please specify
Infection disease			
Neurologic condition (MS/Parkinson's)			
Skin Disease			
Spinal Cord Injury			
Degenerative Joint Disease			

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*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

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

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*Quick*DASH

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:		**NO DIFFICULTY**	**MILD DIFFICULTY**	**MODERATE DIFFICULTY**	**SEVERE DIFFICULTY**	**UNABLE**
1.	using your usual technique for your work?	**1**	**2**	**3**	**4**	**5**
2.	doing your usual work because of arm, shoulder or hand pain?	**1**	**2**	**3**	**4**	**5**
3.	doing your work as well as you would like?	**1**	**2**	**3**	**4**	**5**
4.	spending your usual amount of time doing your work?	**1**	**2**	**3**	**4**	**5**

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❑ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:		**NO DIFFICULTY**	**MILD DIFFICULTY**	**MODERATE DIFFICULTY**	**SEVERE DIFFICULTY**	**UNABLE**
1.	using your usual technique for playing your instrument or sport?	**1**	**2**	**3**	**4**	**5**
2.	playing your musical instrument or sport because of arm, shoulder or hand pain?	**1**	**2**	**3**	**4**	**5**
3.	playing your musical instrument or sport as well as you would like?	**1**	**2**	**3**	**4**	**5**
4.	spending your usual amount of time practising or playing your instrument or sport?	**1**	**2**	**3**	**4**	**5**

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

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