KSHULS
Karen Schultz Hand And Upper Limb Strategies, llc

2982 W Long Dr Unit B 970-331-3435
Littleton, CO 80120 kshuls.cht@gmail.com

PATIENT REGISTRATION

Patient Name _____ Gender ID: Male Female Another Date of Birth __/__/__
Mailing Address_____ Driver's License # _____ State of Issue: _____
City/State/Zip_____ Primary Phone # _____
Physical Address_____ Email _____
City/State/Zip _____

Date of Injury/Illness _____Date of Surgery _____Referring physician_____
Problem _____
_____
Occupation _____ Years at job _____ Employer _____
Employer address _____Employer City/State/Zip _____

Nearest relative not living with patient _____ Relationship to patient _____
Phone _____ Address_____

PERSON FINANCIALLY RESPONSIBLE

Name _____Gender identity: Male Female Another Date of Birth __/__/__
Mailing Address_____ Driver's License # _____ State of Issue: _____
City/State/Zip_____ Primary Phone # _____
Physical Address_____ Email _____
City/State/Zip _____
Occupation _____ Years at job _____ Employer_____
Employer address _____Employer City/State/Zip _____

INSURANCE INFORMATION
(can provide copy of insurance card—both sides—rather than filling this out)

Primary Insurer_____ Secondary Insurer _____
Address _____ Address _____
City/State/Zip _____ City/State/Zip _____
Phone _____Fax _____ Phone _____Fax _____
Certificate/Claim # _____ Certificate/Claim # _____
Policy/Group # _____ Policy/Group # _____
Adjuster/Authorizer _____ Adjuster/Authorizer _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Karen S Schultz/KSHULS to furnish information to referring or family physicians and insurance company concerning my condition and treatments rendered
Signature _____ Date _____
Patient (parent/guardian/custodian)

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AGREEMENT TO PARTICIPATE IN HAND THERAPY

Dear Patient
Thank you for choosing KSHULS as your health care provider. I am committed to successful treatment.

For your first appointment, please bring a copy of all medications and supplements that you are currently taking. Please also bring a brief history of medical procedures you have undergone, injuries and illnesses.

Please understand that payment of your bill is considered a part of the therapy process. The following is a statement of our Financial Policy that we require you to read and to sign prior to treatment.

Payment will be made at the time of each visit via check or cash. Bank transfer may also be arranged after initial payment. I will provide you with a therapy invoice for your records.

Unless canceled at least 24 hours in advance, the policy is to charge for missed appointments at the rate of a normal therapy visit.

Agreement
I, the undersigned, hereby agree to abide by and adhere to these policies. I also agree that in the event of default in the payment of any amount due, if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

Thank you for understanding this Financial Policy. Please let me know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____
Signature of Financially Responsible Party Date