SEATTLE HAND REHABILITATION CLINIC

A DIVISION OF SEATTLE HAND SURGERY GROUP, P.C.

Patient Name _____ DOB _____

Insurance _____

Insurance approved _____ per year (dollar amount or number of visits)

Amount used this year _____

Referral expiration date _____

- **I understand it is my responsibility to have a current therapy prescription (within the past 30 days) signed by a physician, PA-C, or ARNP, faxed to Seattle Hand Rehabilitation Clinic by my first therapy appointment.**

- **I understand that it is my responsibility to verify my insurance coverage for therapy. I am aware that I will be held accountable for any charges/visits that my insurance company does not cover. I have contacted my insurance company and have verified my coverage/approval for physical/occupational therapy services.**

- **I understand I must have this form completed upon my first therapy appointment.**

Patient Signature _____ **Date** _____

Date	Visit #

Date	Visit #

600 BROADWAY, SUITE 440 SEATTLE, WA 98122 (206) 292-6252 24 HOURS OR 1-800-888-6252 FAX (206) 292-7893