Meridian
Hand Therapy

Patient's Name: _____ Date: _____

Your insurance company may not pay for the item(s) or service(s) that are described below. Most insurance companies do not pay for all of your health care costs. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be good reason for your doctor/therapist to recommend it. Right now, in your case, **your insurance company may not pay for**:

- Iontophoresis pads
- Iontophoresis treatment
- Dressing change supplies
- Silicon gel
- Tape/ Coban
- Home exercise equipment
- Wound debridement
- Theraputty
- Tubigrip
- Stockinette
- Electrodes
- Digisleeve
- Ice packs

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have it pay for them yourself. Before you make a decision you should read this entire form.

- Ask us to explain, if you don't understand why your insurance company might not pay.
- Ask us how much these items or services will cost you in case you have to pay for them yourself.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN AND DATE YOUR CHOICE.

☐ Option 1: **YES**, I want to receive these items or services.
I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. If my insurance company denied payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.

☐ Option 2: **NO**, I have decided not to receive these items or services.
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company won't pay.

_____ _____
Date Signature of patient or person acting on patient's behalf

Date:_____

UPPER EXTREMITY FUNCTIONAL INDEX

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with: (Circle one number on each line)

ACTIVITIES	Extreme Difficulty	Quite a bit of Difficulty	Moderate Difficulty	A Little bit of Difficulty	No Difficulty
a. Any of your usual work, housework or school activities	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Lifting a bag of groceries to waist level	0	1	2	3	4
d. Placing an object onto, or removing it from an overhead shelf	0	1	2	3	4
e. Washing your hair or scalp	0	1	2	3	4
f. Pushing up on your hands (e.g., from bathtub or chair)	0	1	2	3	4
g. Preparing food (e.g., peeling, cutting)	0	1	2	3	4
h. Driving	0	1	2	3	4
I. Vacuuming, sweeping, or raking	0	1	2	3	4
j. Dressing	0	1	2	3	4
k. Doing up buttons	0	1	2	3	4
l. Using tools or appliances	0	1	2	3	4
m. Opening doors	0	1	2	3	4
n. Cleaning	0	1	2	3	4
o. Tying or lacing shoes	0	1	2	3	4
p. Sleeping	0	1	2	3	4
q. Laundering clothes. (e.g., washing, ironing, folding)	0	1	2	3	4
r. Opening a jar	0	1	2	3	4
s. Throwing a ball	0	1	2	3	4
t. Carrying a small suitcase with your affected limb	0	1	2	3	4
Column Totals:					

Minimum level of detectable change (90% confidence): 9 points

Score: _____ / 80