Ho Rehab Center

18344 Clark St Ste#208 Tarzana, CA 91356 Phone: (818) 996-8386 Fax: (818) 996-8979

Patient Information

Patient Name: _____ Marital Status: _____ D.O.B.: _____ Age: _____

Address: _____ Gender: *Male* *Female*

City: _____ State: _____ Zip: _____ Last 4 digits of SS#: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Patient Occupation: _____ Work Phone: _____

Employer: _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Referring Physician Information

Referring Physician: _____ Physician Phone: _____

Home Health Care

Are you currently OR have you received Home Health Care services (e.g. PT, OT, or a Nurse visiting your home) this year? *Yes (Date of D/C: _____)* *No*

If *YES* Name of Company: _____ Phone Number: _____

Insurance Information

Have you had Physical or Speech Therapy this YEAR? *Yes* *No*

Is this an auto-accident related injury? *Yes* *No* **Please note Ho Rehab Center does NOT accept liens**

Is this a work-related injury? *Yes* *No*

Please select one of the following: *Medicare OR*

Medicare-Advantage Carrier: _____

Insurance ID #: _____ Group ID #: _____

Secondary/Supplemental Insurance: _____

Primary Insured: _____ Relationship to Subscriber: _____ D.O.B.: _____

Insurance ID #: _____ Group ID #: _____

X _____

Patient Signature **Date**

Patient Health Questionnaire - PHQ

Patient Name: _____

1. Describe your symptoms _____

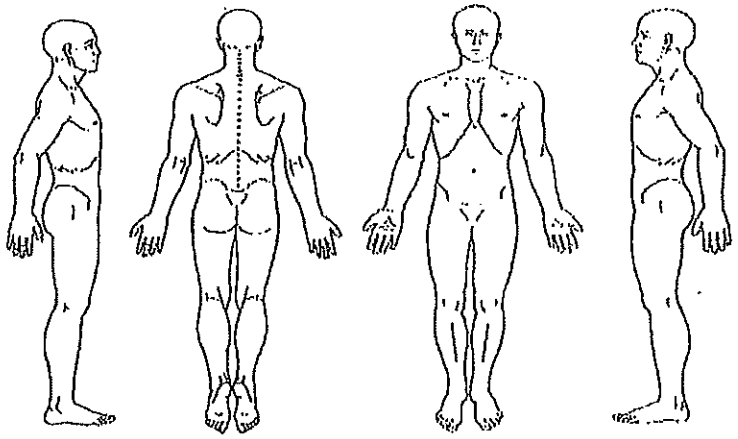
a. Start Date? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp
② Dull ache
③ Numb
④ Shooting
⑤ Burning
⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general, would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:*_____ ③ CT Scan *date:*_____
② MRI *date:* _____ ④ Other *date:*_____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation? _____

Medical History Screening Form

Name: _____ **D.O.B.:** _____ **Date:** _____

Weight: _____ **Height:** _____

Date of last physical examination: _____

Do you have a pacemaker? *Yes* *No*

For Women: Are you currently pregnant or think you might be pregnant? *Yes* *No*

Circle *YES* or *NO*

Have *you* or any of your *immediate* family been diagnosed with:

	Self		Family	
Cancer.....	*Yes*	*No*	*Yes*	*No*
Diabetes.....	*Yes*	*No*	*Yes*	*No*
High Blood Pressure...	*Yes*	*No*	*Yes*	*No*
Angina/Chest pain.....	*Yes*	*No*	*Yes*	*No*
Stroke.....	*Yes*	*No*	*Yes*	*No*
Osteoporosis.....	*Yes*	*No*	*Yes*	*No*
Osteoarthritis.....	*Yes*	*No*	*Yes*	*No*
Rheumatoid arthritis...	*Yes*	*No*	*Yes*	*No*

In the past 3 months have you had or do you experience:

A change in *your health?*.....	*Yes*	*No*
Nausea/Vomiting?.....	*Yes*	*No*
Fever/chills/sweats?.....	*Yes*	*No*
Unexplained weight change?.....	*Yes*	*No*
Numbness or tingling?.....	*Yes*	*No*
Changes in appetite?.....	*Yes*	*No*
Difficulty swallowing?.....	*Yes*	*No*
Changes in bowl or bladder function?.....	*Yes*	*No*
Shortness of breath?.....	*Yes*	*No*
Dizziness?.....	*Yes*	*No*
Upper respiratory infection?.....	*Yes*	*No*
Urinary tract infection?.....	*Yes*	*No*

Are you currently:

Depressed?.....	*Yes*	*No*
Under stress?.....	*Yes*	*No*

Do you have problems with (circle all that apply)

Hearing	*Vision*
Speech	*Communication*

Circle *YES* or *NO*

Do you have a history of?

Allergies/Asthmas?.....	*Yes*	*No*
Headaches?.....	*Yes*	*No*
Bronchitis?.....	*Yes*	*No*
Kidney disease?.....	*Yes*	*No*
Rheumatic fever?.....	*Yes*	*No*
Ulcers?.....	*Yes*	*No*
Sexually transmitted disease?..	*Yes*	*No*
Seizures?.....	*Yes*	*No*

***How are you able to sleep at night?* (circle one)**

Fine	*Moderately Difficult*	*Only with medication*

Do you or have you smoked tobacco in the past? (circle one)

Yes *No*

If yes, _____ packs x _____ years

Last tobacco use: _____

Do you drink alcoholic beverages? (circle one)

Yes *No*

If *YES*, _____ per week

Please list current medications: _____

_____

_____

_____

_____

_____

_____

_____

Internal Use: BMI= 703*(_____lb/_____in^2)

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PLEASE INITIAL EACH SECTION

2023 MEDICARE INFORMATION

_____ The Center for Medicare and Medicaid Services have informed us that effective January 1, 2023 the Medicare deductible is $226.00 and there will be a "cap" of $2,150.00 for Outpatient Physical Therapy and Speech Therapy combined which is based on the Allowed amount not the Billed amount. Physical Therapy visits received at another facility this year are included in this cap, therefore it is very important for the patient/family member/caretaker to inform us of any prior physical/speech therapy in 2023. Medicare no longer limits how much it pays for your medically necessary outpatient physical therapy services in one calendar year. As a courtesy to our patients, we will bill Medicare and most Secondary/Supplemental insurance if the claim does not cross over from Medicare directly. The Medicare Part B Deductible is the responsibility of each patient. We are NOT MediCal providers; therefore, we do not bill MediCal.

MEDICARE SECONDARY/SUPPLEMENTAL AUTHORIZATION AND FINANCIAL POLICY

_____ I irrevocably assign Ho Rehab. Center, Inc. all insurance payments for professional services rendered including those that are billed to Medicare and Medicare Secondary/Supplemental. In the event the insurance benefits are paid directly to me, I agree to make immediate payments to Ho Rehab. Center, Inc. I understand that Ho Rehab. Center, Inc. will bill my insurance company from the information I have provided. All copayments, deductibles, coinsurances, or non-covered services are to be paid on the date of service or within 30 days of the date of treatment according to the office policies. It is your responsibility to review your insurance benefits and EOB's. You agree that if your insurance takes more than 60 days to respond to your insurance claim that we shall consider your services your financial responsibility. Payments are due upon receipt of the statement. Patient account balances over 90 days are subject to transfer to an outside collection agency. You agree to be liable for all such collection expenses, legal fees and court costs.

_____ **I understand that if I fail to show up or fail to cancel 24-hours prior to my scheduled appointment time I will be charged $50.00 for that appointment ******

_____ Ho Rehab. Center, Inc. is committed to providing Physical Therapy as directed by your referring physician. We hope that you have a positive experience and reach the goals set by you and your Doctor of Physical Therapy. We cannot guarantee FULL RECOVERY or unforeseeable adverse reaction to treatments. I understand that my candidacy for Physical Therapy rehabilitation will be dependent upon my ability and willingness to improve. If your results do not meet your full expectations or adverse reactions occur from your treatment, your financial responsibilities will not be waived.

I have read and attest that I fully understand and agree to the terms of the policy above.

Signature: _____ Date: _____

Print Name: _____

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To all Medicare Patients:

Based on Medicare Policy, patients are NOT allowed to have Home Health Care while receiving Outpatient Physical Therapy Services also known as Consolidated Billing.

Home Health may include any medical personnel **coming to your home** for physical therapy, blood pressure or blood sugar checks, wound care, etc. These charges are billed to Medicare.

Please inform our front office staff or your Therapist if you are currently receiving Home Health or a Home Health Episode **has begun at any time while** you are receiving Outpatient Physical Therapy at Ho Rehab. Center. In that case, your current treatments at Ho Rehab. Center will be stopped and will be resumed once you provide us with discharge summary including date of discharge on the Home Health Agency letterhead.

Failure to inform our front office staff or your Therapist will result in payment for physical therapy services becoming the patient's responsibility.

Please feel free to ask any staff member for details or if you have any questions/concerns.

I have read and understand Medicare's Policy on NOT being allowed to have any form of Home Health while I am receiving physical therapy at Ho Rehab. Center, Inc.

Please sign _____ **Date** _____

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NOTICE OF PRIVACY PRACTICES AND POLICIES

It is the policy of our practice that all staff at Ho Rehab Center, Inc. preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its Doctors of Physical Therapy and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree. Patients should not be afraid to provide information to our practice and its staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice, it's Doctors of Physical Therapy and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practice and Policies.
- Collect, use, and disclose PHO only in conformance with state and federal laws and current patient covenants and/or authorization, as appropriate, our practice and its therapist and staff will not use or disclose PHI for uses outside of practice's TPO (treatment, payment, and healthcare operations), such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Recognize the PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice, its Doctors of Physical Therapy, and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients. Recognize that patients have a right to privacy. Our practice, its Doctors of Physical Therapy, and staff respect the patient's individual dignity at all times. Our practice, its Doctors of Physical Therapy, and staff will respect a patient's privacy while providing the highest quality medical care possible within our scope of practice and within guidelines of efficient facility administration.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Our practice, its Doctors of Physical Therapy, and staff will treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements. Additionally, we will not disclose PHI data unless the patient (or his/her written authorized representative) has properly consented to or authorized the release, or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical records, the patient has a right to inspect and obtain a copy of his/her PHI. Our practice and staff will permit a patient access to his/her medical records when his/her written request is approved by our practice. If we deny his/her request, we then must inform the patient of his/her right to request review of our denial. In such case, we will have an on-site healthcare professional review the patient's appeal.
- Provide patients an opportunity to request an amendment and correction to his/her medical record if he/she believes the information provided in the PHI to be inaccurate or incomplete in accordance with the law and professional standards.
- All Doctors of Physical Therapy and staff at Ho Rehab Center, Inc. will maintain a list of all disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization.
- All Doctors of Physical Therapy and staff at Ho Rehab Center, Inc. must adhere to this policy. Our practice will not tolerate violation of this policy. Violation of this policy is grounds for disciplinary action,
- Our practice may change this privacy policy in the future.
- Copy of the Privacy Practice and Policy is available upon request with the front office.

Signature: _____ Date: _____

Print Name: _____