Ho Rehab Center

Patient Information

Patient Name:	D.O.B:	Marital Status:	Age:
Address:		Gender: Male☐ Female☐	
City:	State:	Zip:	Last 4 Digits S.S #:
Home: ( )		Cell Phone: ( )	
E-mail Address:			
Patient Occupation:		Employer:	
Phone: ( )			
Spouse/Guardian Name:		Spouse/Guardian D.O.B:	
Address:	City:	State:	Zip:
Spouse/Guardian's Last 4 Digits S.S. #:		Relationship:	
Phone: ( )		Cell Phone: ( )	

Emergency Contact Information

Emergency Contact Name:	Relationship:
Phone: ( )	Other Phone: ( )

Nature of Illness or Injury

What are we treating you for?		
Is this a work-related injury? Yes☐ No☐	Is this an auto-accident related injury? Yes☐ No☐	
Date of Onset:	Referring Physician:	Phone of Physician: ( )

Insurance Information

Please check one of the following: **PPO**☐ **Medicare**☐ **Medicare *Advantage***☐ **VA/Tricare**☐ **Auto**☐ **Worker's Comp**☐		
Are you currently **OR** have you received home health services during this year? Yes☐ No☐		
Have you had PT, OT, Speech, Chiro, or Acupuncture this year? Yes☐ No☐		
Primary Insurance:		
Primary Insured:	Relationship to Subscriber:	D.O.B.:
ID #:	Group #:	
Secondary Insurance:		
Primary Insured:	Relationship to Subscriber:	D.O.B.:
ID #:	Group #:	
Workers Comp., Ins. Co. Name:		Claim #
Adjuster's Name:	Phone: ( )	

Ho Rehab Center does NOT accept liens

X_____

Patient Signature **Date**

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

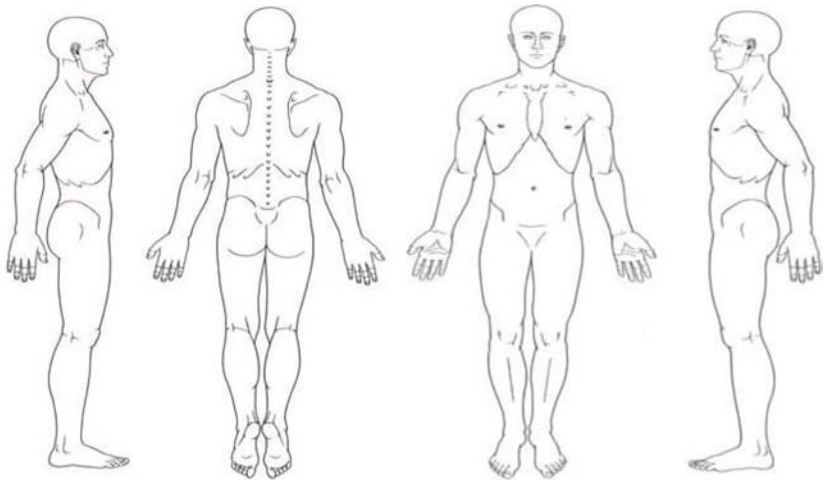
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- ○ Constantly (76-100% of the day)
- ○ Frequently (51-75% of the day)
- ○ Occasionally (26-50% of the day)
- ○ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ○ Sharp ○ Shooting
- ○ Dull ache ○ Burning
- ○ Numb ○ Tingling

4. How are your symptoms changing?

- ○ Getting Better
- ○ Not Changing
- ○ 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)

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ 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)

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

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

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

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8. Who have you seen for your symptoms?

☐ No One ☐ Medical Doctor ☐ Other
☐ Chiropractor ☐ Physical Therapist

a. What treatment did you receive and when? _____

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

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

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

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

☐ This Office ☐ Medical Doctor ☐ Other
☐ Chiropractor ☐ Physical Therapist

10. What is your occupation?

_____

○ Professional/Executive ○ Laborer ○ Retired
○ White Collar/Secretarial ○ Homemaker ○ Other
○ Tradesperson ○ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

○ Full-time ○ Self-employed ○ Off work
○ Part-time ○ Unemployed ○ Other

Patient Signature _____ **Date** _____

Ho Rehabilitation Center, Inc.
Medical History Screening Form
Physical Therapy

Circle YES or NO …

Have you or any immediate family member ever been told you have: ……..Self Family

	Self		Family	
Cancer? ……	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes?.....	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure?..	☐ Yes	☐ No	☐ Yes	☐ No
Heart Disease?.....	☐ 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 <u>your</u> 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 bowel or bladder function?....	☐ Yes	☐ No
Shortness of breath?.....	☐ Yes	☐ No
Dizziness?.....	☐ Yes	☐ No
Upper respiratory infection?.....	☐ Yes	☐ No
Urinary tract infection?	☐ Yes	☐ No

Additional Medical Information:

_____

_____

_____

_____

_____

_____

Circle Yes or No …

Do you have a history of:

Allergies/Asthma?.....	☐ 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

Are you currently:

Pregnant?.....	☐ Yes	☐ No
Depressed?.....	☐ Yes	☐ No
Under Stress?.....	☐ Yes	☐ No

Are your symptoms: (check one)

☐ Getting Worse ☐ The same ☐ Improving

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

☐ Fine ☐ Moderately Difficulty ☐ Only with medication

Do you have problems with …? (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco?

☐ **YES** ☐ **NO**

If yes, _____ Packs x _____ Years
Last tobacco use: _____

Do you drink alcoholic beverages?

☐ **YES** ☐ **NO**

If yes, _____/week

Date of last physical examination: _____

List of medications currently using: _____

_____

_____

_____

_____

Ho Rehab. Center, Inc.
18344 Clark St. Suite 208
Tarzana, Ca 91356
(818) 996-8386
Fax: (818) 996-8979
Horehab.com

To all Medicare Patients:

The Centers for Medicare and Medicaid Services have informed us that effective January 1, 2017 the Medicare deductible is $183.00 and there will be a cap of $1980.00 for Outpatient Physical Therapy and Speech Therapy combined. A separate cap will be applied for Occupational Therapy. Our calculations of $1980.00 are based on the **allowed amount.** For most of our patients, this amount will occur after approximately 15 physical therapy treatments. *Physical Therapy visits received **at another facility** this year are included in this cap therefore it is very important for the patient to inform us of any prior physical/speech therapy.*

Several options are available once the cap has been reached. Medicare has compiled a list of "automatic exceptions" to the therapy cap, which will be discussed with you by your physical therapist. If your diagnosis is not covered under the automatic extension, your physical therapist and your referring doctor may feel that continued physical therapy is medically necessary and Medicare will continue to be billed until the maximum amount of $3,700.00 is reached. Beyond this amount you will be required to sign an ABN (Advanced Beneficiary Notice) form that is an official CMS form. If your physical therapist has determined that your physical therapy is not "medically necessary" but you would benefit from a "maintenance program", then a cash payment plan will be discussed with you by the office staff and an ABN form will be required.

As a courtesy to our patients, we will bill Medicare and most coinsurances. The Medicare Part B deductible for 2017 is $183.00 per calendar year and is the responsibility of all patients. *We are **not** MediCal providers therefore **we do not bill MediCal.***

Please feel free to speak with your physical therapist/front office staff if you have any questions or concerns regarding this matter.

Sincerely,

Larry Ho, DPT, OCS and staff

I have read and understand the information above regarding the $1,980.00 cap and Medicare Part B deductible of $183.00 imposed by the Centers for Medicare and Medicaid Services effective January 1, 2017.

_____

Sign Date

_____

Print name

Revised 11/19/17 sr

Ho Rehab. Center, Inc.
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Tax ID# 95-4643526

FINANCIAL POLICY

Regarding Late Fees, Late Cancellations/No Shows

(PLEASE READ COMPLETELY BEFORE SIGNING!)

I **irrevocably** assign to **Ho Rehabilitation Center, Inc.** all payments for professional services rendered. I understand that **Ho Rehabilitation Center, Inc.** will bill my insurance company from the information that I have provided. I understand that the payment of all charges incurred is my responsibility and the portion not paid by the insurance carrier is payable by me within **60 days** from the date of treatment. *Accounts not paid within **60 days** of insurance payment will be charged a late fee of $25.00 per month.*

I also understand that if I fail to show up or fail to cancel 24-hours prior to my scheduled appointment time; I will be charged $25.00 for that appointment. Patients with a pattern of canceling or missing appointments will be required to call for same day appointments. If I have any questions regarding the above financial policy, I will contact any of the office staff.

☺DATE: _____SIGNATURE OF PATIENT_____

☺Patient's or authorized person's signature (if under 18 years of age)

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NOTICE OF PRIVACY PRACTICES AND POLICIES

It is the policy of our practice that all staff at Ho Physical Therapy preserves 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 Practices and Policies.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorization, as appropriate. Our practice and its therapists and staff will not use or disclose PHI for uses outside of practice's TPO (treatment, payment and health care operations), such as marketing, employment, life insurance applications, etc. without an authorization from the patient
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and 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 and its Doctors of Physical Therapy and staff respect the patient's individual dignity at all times. Our practice and 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 and 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 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 a review of our denial. In such cases, 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 Physical Therapy 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 Physical Therapy must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action.
- Our practice may change this privacy policy in the future.

I, _____, have received and reviewed the Notice of Privacy Practices and Policies.

Signature: _____ Date: _____

I *understand* the Notice of Privacy Practices and Policies, but have chosen *not* to take a copy of these policies.

Signature: _____ Date: _____

MEDICARE PROGRAM PATIENT CONSENT AND

PAYMENT AUTHORIZATION

I request rehabilitation services from **HO REHAB CENTER, INC.** and consent to the treatment ordered by my physician who monitors, approves and certifies the need for my care. I consent to the release of information and a copy of my clinical records to **HO REHAB CENTER, INC.** by any health care provider.

I do not receive Medicare benefits from a managed care organization and I am eligible to receive Medicare Part B benefits from a provider of my choice. I certify that the information given by me in applying for payment under the Medicare Program (Title XVIII of the Social Security Act) is correct. I authorize benefits be made on my behalf.

(Please check one)

☐ **I do not have Medicare supplemental insurance.**

☐ **I have Medicare supplemental insurance with:**

Name of Company: _____
Claim Mailing Address: _____
City/State/Zip Code: _____
Telephone Number: _____

☐ **I have health benefits provided by the Medi-cal program.**

I hereby assign payment of any Medicare supplemental insurance benefits to **HO REHAB CENTER, INC.** In the event the insurance benefits are paid directly to me, I agree to make immediate payment to **HO REHAB CENTER, INC.** . If I do not have supplemental insurance, I agree to pay the deductible and/ or coinsurance when billed unless other arrangements are made in advance.

The undersigned certifies that he/ she has read the foregoing and is the patient or is duly authorized by the patient to provide the above information and accept its terms.

Insurance ID/Member Number _____Group Number_____

Patient Name (print) _____**Clinical Record #_____**

⇉Signature_____Date_____

Witness_____Date_____

If the patient did not sign this form, what is the relationship of the signer to the patient ?

_____

Reason for not signing ?

_____