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 _____

_____

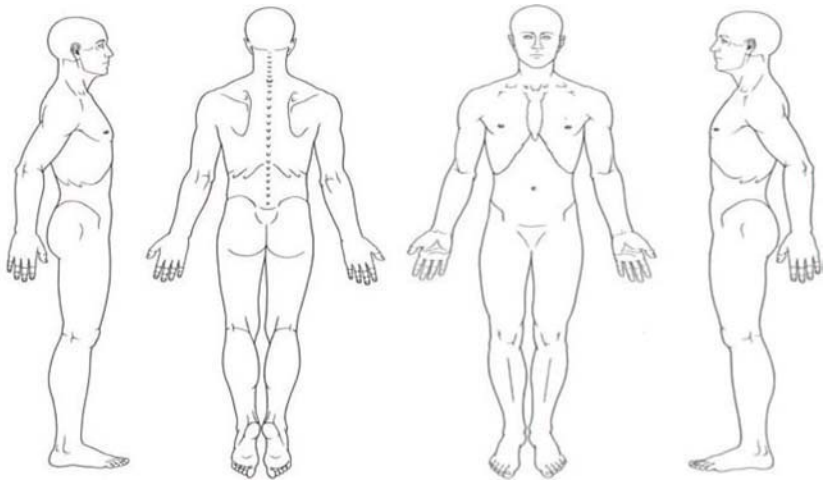
a. When did your symptoms start? _____

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: _____

_____

_____

_____

_____

He Rehabilitation Center, Inc.
18344 Clark Street, Suite 208
Tarzana, CA 91356
(818) 996-8386, (818) 996-8979 (fax)

Financial Policy

I hereby authorize **HO REHABILITATION CENTER, INC.** to perform Physical Therapy as prescribed by my physician and to furnish and use the information provided for all matters concerning the treatment, payment and healthcare operations (TPO) related to this condition.

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 accrue interest. **I understand that my insurance company may quote benefits to Ho Rehabilitation Center; however, it is not a guarantee of payment. I will refer to my insurance manual to verify physical therapy benefits and inquire about co-pay and deductible portions. My estimated Co-payment is due upon arrival to each physical therapy visit.**

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. This charge will not be charged to my insurance company. Patients with a pattern of cancelling or missing appointments will be required to call for a same day appointment. I also understand that if I **arrive late to my appointment by more than 15 minutes** I may not be seen and will be charged a $25.00 for a late cancellation fee. If I have any questions regarding the above financial policy, I will contact any of the office staff.

I understand that if my injury is the result of an accident and involves an attorney **Ho Rehabilitation Center, Inc.** will provide a copy of my medical records at the time of discharge. California Law allows a charge of $0.25 per page which will be due upon receipt of records. There will be an added fee for postage if records are mailed. I also understand that **Ho Rehabilitation Center, Inc.** does **NOT** accept liens

I have read and understand the above financial policy and I agree to the above regarding procedures and payment of service.

I authorize the release of any medical or other information necessary to process these claims and I authorize payment of medical benefits to the undersigned physicians or suppliers for services rendered.

DATE: _____ **SIGNATURE OF PATIENT: _____**
Patient's or authorized person's signature (if under 18 years of age)

Ho Rehab. Center, Inc.
18344 Clark St. Suite 208
Tarzana, Ca. 91356
(818) 996-8386
FAX (818) 996-8979
Tax ID# 95-4643526

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: _____