Ho'Rehab Center
18376 Clark Street Tarzana, CA 91356
Phone: 818-996-8386 Fax: 818-996-8979 Email: info@horehab.com

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**

MC

Patient Health Questionnaire - PHQ

Patient Name: _____

1. Describe your symptoms _____

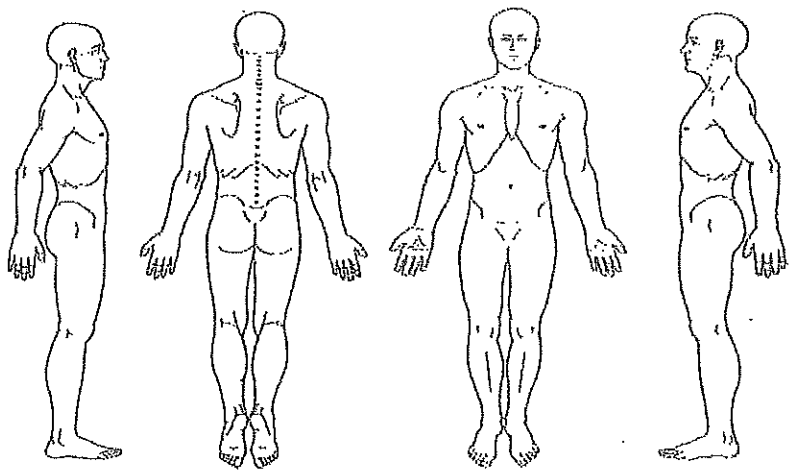
a. Start Date? _____

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
⑤ 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

Patient Name: _____

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 bowel 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/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*

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

Fine	*Moderately Difficult*	*Only with medication*

Do you currently smoke 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 Statement

_____ Ho Rehab Center, Inc. does NOT automatically schedule appointments for you. Please make sure that you review your own schedule with the front office for continuity of care.

SCHEDULING

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

FINANCIAL POLICY

_____ I irrevocably assign Ho Rehab Center, Inc. all insurance payments for professional services rendered. I understand that Ho Rehab Center, Inc. will bill my insurance company from the information that I have provided. **Per office policy, all copayments, deductibles, coinsurances, or non-covered services are to be paid on the date of service or within 30 days of date of treatment.** It is my responsibility to review my insurance benefits and EOB's. It is also my responsibility to notify this office of any changes in coverage and I understand that a lack of notification may result in unpaid claims that will become my financial responsibility. I agree that if my insurance company takes more than 60 days to respond to any insurance claim, Ho Rehab Center, Inc. shall consider those services my financial responsibility. Payment is due upon the receipt of the statement. Patient account balances over 90 days are subject to transfer to an outside collection agency. I agree to be liable for all such collection expenses, legal fees, and court costs.

LIENS

_____ Ho Rehab Center, Inc. does NOT accept liens. If you have an attorney, please notify the front office. Your insurance company will be billed and any deductibles, copays, coinsurances will be your responsibility. At the end of your treatment, we can provide you with your medical records for $0.25 per page.

PATIENT CARE

Ho Rehab Center, Inc. is committed to providing Physical Therapy as directed by your referring physician. **An updated prescription is required in order to continue with your Physical Therapy plan of care.** We look forward to helping you reach the goals set by you and your Doctor of Physical Therapy. We cannot guarantee FULL RECOVERY or unforeseeable adverse reactions to treatments.

_____ I understand that my candidacy for Physical Therapy rehabilitation will be dependent upon my ability and willingness to improve. **If my results do not meet my full expectations or adverse reactions occurs from my treatment, my financial responsibilities will not be waived.**

PATIENT DISCHARGE

_____ Ho Rehab Center, Inc. reserves the right to discharge a patient for any reason. Please note that you may be discharged for failure to meet your obligations as well as care quality considerations under this document. Failure to comply with treatment plans as outlined by your practitioner, may result in early discharge.

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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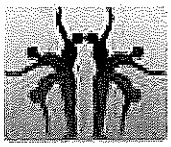
NOTICE OF PRIVACY PRACTICES AND POLICIES

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, its 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 Policy is available upon request with the front office.

Signature: _____ Date: _____

Print Name: _____



Ho Rehab Center

Der-how Huang, DPT, OCS, CSCS, Gian Wu, DPT, Yi Sheng, DPT, Chengyan Wu, DPT

Text Appointment Reminder

I authorize Ho Rehabilitation Center to send me appointment reminders by Text to my Mobile Phone Line: (_____) _____ - _____ .

I understand that I will ***Not be able to reply*** to the text message and that I will be responsible to call the office for any changes to my PT schedule.

Any Last-minute changes to my schedule, less than 24 hours, may result in an inaccurate Text reminder.

I authorize Text Reminders **I do not authorize Text Reminders**

Initial _____

No-Show and Late Cancelation Fees

I understand that I will be responsible for a No-Show Fee of $50.00 each time that I do not show up for my scheduled appointment or a Late-Cancelation Fee of 50.00. when I fail to give a 24-Hour notice.

I understand the appointment fee policy

Initial _____

Statement of Account

I authorize Ho Rehabilitation Center to send me an email statement, if I have a balance due.

I understand that the email statement will come from a No-Reply address and that I will not be able to reply to the communication. I will however, continue to have the option to contact the office to pay by phone or send in, my payment by mail.

I authorize Ho Rehab. Inc., to send me an electronic statement when necessary

Initial _____

Name Date Signature: