MEDICAL HISTORY

Name ________________________________DOB __/___/___ Occupation _____________________

Do you now or have you ever had any of the following: *(check all that apply)*

☐ Diabetes
☐ Arthritis
☐ High blood pressure
☐ Heart disease
☐ Pacemaker
☐ Vascular disease
☐ Headaches
☐ Kidney problems
☐ Fever/Night Sweats

☐ Rheumatoid Arthritis
☐ Open wounds
☐ Current infection(s)
☐ Hypersensitivity to Heat/Cold
☐ Allergies
☐ Females-Presently pregnant
☐ Seizures
☐ Metal in body
☐ Cancer/Tumor

☐ Thyroid problems
☐ CVA / Stroke
☐ Previous fractures
☐ Osteoporosis
☐ Anxiety
☐ Substance abuse
☐ Previous surgeries
☐ Other
☐ NONE OF THE ABOVE
☐ Incontinence

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY.
IF A QUESTION DOES NOT APPLY LEAVE IT BLANK.
THE THERAPIST WILL DISCUSS ANY QUESTIONS WITH YOU.

1) Date symptoms / injury began ____

2) Where did symptoms / injury? _____ **Home**_____**Work**_____**Car Accident**_____**Other**_____**Unknown**

3) How did symptoms / injury occur?____

4) Have you had **Injections**______**X-rays**______**MRI**______**EMG**______**Other**____

5) Have you been hospitalized for this problem? ☐ NO ☐ YES , How long? ____

6) Did you have surgery for this incident? ☐ NO ☐ YES, What type? ____

7) Are you taking **ANY** medication? ☐ NO ☐ YES, What type?

____

8) What are your personal goals for Physical Therapy?____

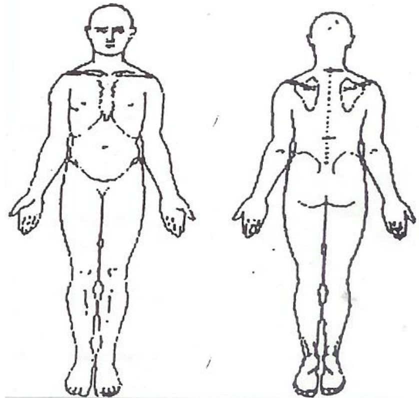
9) Have you had Physical Therapy this year?________YES________NO

*If so what kind of Therapy? **Home**______**Out Patient**______**Out Patient Hospital**_____**In Patient**_____

10) Preferred Learning Style **Verbal Instruction**_____**Written Instruction**_____**Demonstration**_____

11) Do you use Tobacco_________Consume Alcohol_________

<u>Mark on the drawing the areas you feel pain or numbness</u>.



Height________**Weight**_________

Thank you for telling us your history. This enables us to provide you with the best possible treatment program.

PLEASE PRINT CLEARLY

Personal Information

First Name ______________________(Preferred)_____________________ Last _____________________

SSN:________________________________ D/O/B: ___________________________ Sex: M / F

Address: _____________________________ City/State: _______________________Zip: _________________

Home phone: ___________________________________ Cellular: ___________________________________

Language: English / Spanish / Other Ethnicity: _______________________________________

Marital Status: Single / Married / Other E-Mail Address _________________________________

Employer: _____________________________________ Occupation: ______________________________

Employer Address: _____________________________________ Work Phone: __________________________

Insured / Responsible Party (if different from above)

Name _____________________________________ Insurance identification# _______________________

Relationship _________________________ D/O/B: ___________________________ Sex: M / F

Address: _________________________________ City/State: ____________________ Zip: _______________

Home phone: _____________________ Cellular: _______________________ Work: ___________________

Employer name: ______________________________ Do you have a secondary Insurance? YES NO

Emergency Contact Information

Name _____________________ Relationship: _________________ Daytime phone: _____________________

Patient Certification and Signature

I certify that all the information provided herein is true and correct.

____ __________________

Patient / Responsible Party Signature Date

HOPE REHAB Patient Consent

Patient Name: ______________________ Guardian/Responsible Party Name:___________________________

Release of Information

All information provided herein is true and correct.

I hereby consent to treatment.

I give permission to *Hope Rehab* and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize *Hope Rehab* and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician and or other medical professionals as it relates to my treatment.

Information without patient identifiers may be used for quality assurance purposes.

I have read and understand the above release.

____ __________________________

Patient or Guarantor signature Date

Assignment of Benefits

I authorize payment directly to *Hope Rehab*, its subsidiaries and/or affiliates for services.

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

____ __________________________

Patient or Guarantor signature Date

Payment Guarantee

I agree to pay *Hope Rehab*, its subsidiaries and/or affiliates for the services provided to me. If any law, such as workers' compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for the speedy collection from my third-party payer. Where the law or an insurance contract does **not** prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of *Hope Rehab*, and/or its affiliates or subsidiaries.

____ __________________________

Patient or Guarantor signature Date

NOTICE OF PRIVACY PRACTICES

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

FOR TREATMENT

We may use health information about you to provide you with rehabilitation or related services. We may disclose health information about you to other therapists, doctors (your medical/dental providers), nurses, technicians, clinical students or other clinical or support personnel needed to assist in optimal care. This might also include disclosing or using health information to educate and train a designated family member to assist with home rehabilitation or activities support.

FOR PAYMENT

We may use and disclose health information about you so that treatment and services you receive may be billed to and payment may be collected from your insurance company or liable party. We may need to disclose health information to your health plan and or payer about treatment you are going to have in order to obtain prior approval or to determine whether there is specific coverage for the services to be delivered to you.

CONSENTS, AUTHORIZATIONS AND ACCESS

Currently, there is no federal regulation that requires your healthcare provider to obtain consent for treatment, payment or associated healthcare operations. However, all providers are required to adhere to the privacy regulations stipulated in the Health Insurance Portability and Accountability Act (HIPAA) effective April 2001.

The primary focus of the privacy section of the HIPAA is to require that health care providers mange all health care information in a confidential and “need to know” only basis. This includes paper documents, electronic data and telephonic communications. HIPAA requires that all patients have full access to their health information and that they are given the right to review, copy and amend it, as specifically requested.

While consents for provider services are unnecessary, authorizations for use of health information outside of treatment, treatment-related operations and/or payment are required. A signed authorization form giving permission to utilized protected health information, for other than the aforementioned, must be obtained prior to disclosing or using private health information. The Act clearly states that the health care provider may not restrict access to services or in any way penalize a patient in the event of authorization declination or revocation.

Facility Policy:
It is the policy of Hope Rehab that health information is only shared with referring providers, payors, and practicing providers of Hope Rehab. A release of health information form Is required if health information is to be shared with any other person or entity

✸ *Signature only signifies receipt of Privacy Notice*

____ ______________________

Patient / Guarantor signature *date*