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
☐ 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

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.

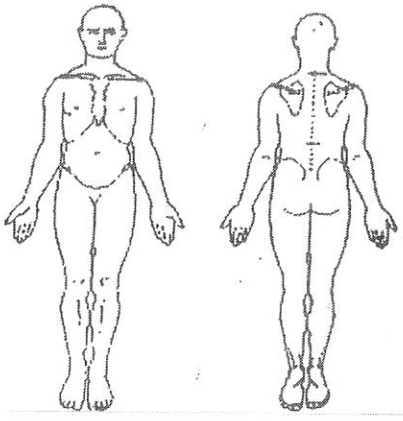
1) Date symptoms / injury began _____
2) Where did symptoms / injury occur **Home**, _____ **Work**, _____ **Car Accident**, _____ **Other,** ____ **Unknown**_____
3) How did symptoms / injury occur _____
4) Have you had Injections_____ **X-rays** _____ **MRI**_____ **EMG**_____ **Other**_____
5) Have you been hospitalized for this problem? ☐ NO ☐ YES, How long? _____
6) Did you have surgery? ☐ NO ☐ YES, What type? _____
7) Are you taking **Any** medication? ☐ NO ☐ YES, What type?

_____

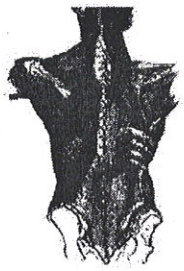
_____

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**_____**OutPatient**_____**OutPatient Hospital**_____ **InPatient**_____
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>.



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: _____

Cell Phone: _____ Home Phone:_____

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

Release of Information

All information provided herein is true and correct. I hereby consent to treatment. I give permission to *Hope RehabPhysical Therapy* 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 Physical Therapy* to obtain medical records and/or professional information from my physician and or other medical professionals as it relates to my treatment.

_____ _____

Patient or Guarantor signature Date

Assignment of Benefits

I authorize payment directly to *Hope Rehab Physical Therapy* 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 Physical Therapy* 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, I acknowledge responsibility for any and all account balances.

The Financial Responsibility 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 Physical Therapy.*_____ (please initial)

Voice Message

Regarding appointment changes, account balance, authorization/continuation of treatment I give permission for *Hope Rehab Physical Therapy* to leave a

- ☐ Voicemail
- ☐ Text message
- ☐ Email

☐ I prefer not to have voicemail message, text messages or emails from the clinic

Observation/Internship

Hope Rehab Physical Therapy may have observation students or interns as part of their education requirements.These students abide by the same rules of confidentiality as our staff_____ . (please initial)

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 Accessibility 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*

Photography Consent Form

Our clinic loves to celebrate the dedication and hard work of our patients. We love to spread encouragement to others by publishing pictures on our website, Facebook, and our Instagram page of our graduates. On Graduation Day our patients will receive a Hope Rehab T-Shirt and have their picture taken with their Physical Therapist!

I,_____ (Print Name)

Hereby: GRANT PERMISSION / DO NOT GRANT PERMISSION (circle one) for Hope Rehab Physical Therapy to use photographs of myself on social media such as their website, Facebook page, Instagram page, and in the clinic.

Signature:_____ Date_____

Printed Name:_____ Date _____

What is Home Health?

Home Health care includes skilled nursing care, as well as other skilled care services, like physical and occupational therapy, speech-language pathology services. Services may also include medical social services, and assistance from a home health aide.

These services may be provided by a variety of health care professionals in your home. If you are receiving Home Health of any kind, the Home Health staff should provide and help coordinate **ALL** your care and/or therapy your doctor orders.

Medicare does not pay separately for physical therapy services provided to patients enrolled in a Home Health Care Agency. Therefore, I _____ **am /am not** having any kind of Home Health Services at this time or prior to the first date of my physical therapy treatments with Hope Rehab Physical Therapy. During my course of treatment with Hope Rehab Physical Therapy, if I begin Home Health, I will notify Hope Rehab Physical Therapy Immediately. Otherwise, I fully understand that I will become financially responsible for my physical therapy treatments

Patient Signature _____ Date _____