HO PHYSICAL THERAPY

9675 BRIGHTON WAY SUITE 250
BEVERLY HILLS, CA 90210
(310) 278-5337
FAX: (310) 278-6204

PLEASE PRINT

PATIENT'S NAME_____SS#_____AGE _____

BIRTHDATE_____MARITAL STATUS_____DRIVER'S LIC#_____

HOME ADDRESS_____TEL#(___)_____

_____

PATIENT'S OCCUPATION_____

EMPLOYER_____TEL#(___)_____

BUSINESS ADDRESS _____

_____

NAME OF SPOUSE / PARENT_____TEL#(___)_____

SPOUSE / PARENT'S EMPLOYER_____TEL#(___)_____

BUSINESS ADDRESS _____

_____

IN CASE OF EMERGENCY NOTIFY_____TEL#(___)_____

ADDRESS_____RELATIONSHIP_____

_____

TYPE OF INSURANCE: PRIVATE_____MEDICARE _____WORK COMP_____

PRIMARY INSURANCE CARRIER_____POLICY #_____

INSURED'S NAME_____GROUP #_____

SECONDARY INSURANCE CARRIER_____POLICY #_____

INSURED'S NAME_____GROUP #_____

IF THIS IS A JOB INCURRED INJURY, WE WILL NEED THE FOLLOWING:

NAME OF W/C INSURANCE CARRIER_____

POLICY #_____CLAIM #_____

ADJUSTER_____TEL #(___)_____

I hereby authorize **HO PHYSICAL THERAPY** to perform physical therapy as prescribed by my physician, to furnish information to the above insurance carrier concerning this illness and I irrevocably assign **HO PHYSICAL THERAPY** all payments for professional services rendered.

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.

I understand that I may be charged for a regular visit if I do not show up or fail to give 24 hours cancellation notice for my scheduled appointment.

DATE: _____PATIENT'S SIGNATURE_____

(PARENT / GUARDIAN IF UNDER 18)_____

BRIEF MEDICAL HISTORY

Nature of your illness or injury_____

Date of Onset_____Referring Physician _____

1. Have you ever had major surgery or injury? YES_____NO_____
   If so, what kind and when?

   Date_____Type_____

   Date_____Type_____

   Date_____Type_____

2. Have you ever been diagnosed as having any of the following conditions?

   YES NO Cancer. If YES, describe what kind and when?_____
   YES NO Heart Problems. If YES, what is the nature of the problem?_____
   YES NO Do you have a pacemaker?
   YES NO High Blood Pressure
   YES NO Diabetes
   YES NO Depression
   YES NO Hepatitis
   YES NO Tuberculosis
   YES NO Other. If YES, please explain_____
   YES NO For women, are you currently pregnant or think you might be pregnant?

5. Have you recently noted:

   YES NO Dizziness
   YES NO Numbness or tingling
   YES NO Nausea or vomiting
   YES NO Weight loss or gain
   YES NO Fatigue
   YES NO Weakness
   YES NO Fever, chills, or sweats

6. Please list all medications that you are currently taking

   _____

   _____

   _____

7. Do you have any skin allergies to latex, lotions, body creams, oils, etc.? YES_____NO_____

8. Please list any other allergies that we should know about

   _____

   _____

   _____

9. Is there any other important information that you feel we should know about?

   _____

   _____

   _____

HO PHYSICAL THERAPY
9675 Brighton Way, Suit 250
Beverly Hills, CA 90210
Tel: 310-278-5337
Fax: 310-278-6204

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 the practice's TPO (treatment, payment and health care operations), such as marketing, employment, life insurance applications, and etc. without an authorization from the patient.
- Recognize the 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 measure 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 his 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: _____