INTAKE FORM

Date: _____

Patient Full Name: _____ Age: _____ Sex: ❑ Male ❑ Female

Social Security #: _____ Date of Birth: _____ ❑ Single ❑ Married

Address: _____ City/State/Zip:_____

Cell Phone: _____ Email Address:_____

Emergency Contact Person Name:_____ Emergency Contact Phone #_____

Primary Physician:_____ City/State:_____ Phone #:_____

If patient is a MINOR, parent/guardian's name and signature here: _____

Have you had Therapy Services before: ❑ Yes ❑ No If Yes, how long: _____

STRESS Level : 1 low----2----3----4----5 high What's the main cause? _____

NUTRITION: What is your level of nutrition knowledge? ❑ None ❑ A little ❑ Medium ❑ A Lot

SUPPORT STRUCTURE: Who do you have nearby that is close to you? ❑ Family ❑ Friend(s) ❑ None ❑ Other: _____

Name something that is really important to you (or really enjoy doing)? _____

How did you hear about us? ❑ Doctor ❑ Friend/Family ❑ Internet ❑ Facebook ❑ Advertisement ❑ Other: _____

We offer appointment reminders, which option would you like? ❑ Automated phone call ❑ Text Message ❑ E-mail

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IMPORTANT RULES & POLICIES

1. **Late Policy: If I'm late more than 10-minutes to my appointment, I may be rescheduled or asked to wait for next available open time slot.**
2. **48-Hour advance notice is required for changes to my appointment otherwise a $25 fee may apply.**
3. **Co-pays and/or deductibles are due prior to treatment starts.**
4. **Not showing for an appointment without notice (or less than 48-hours in advance) will result in a $25 fee added to my account.**
5. **Cell phones must be shut OFF or silent.**
6. **Children requiring supervision are NOT allowed to attend sessions with you without prior authorization.**
7. **If you are experiencing any financial hardship, please notify us immediately so we can create a payment program that is feasible.**
8. **If for any reason, you are NOT satisfied with the care received, please call our administrator at (321) 445-5074.**
9. **I have read and agree to the polices above. Signature_____ Date: _____**

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Hohman Rehab and the physical/occupational therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Hohman Rehab, and any other entity, person, or associate, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Hohman Rehab, or by any other person. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Hohman Rehab and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Hohman Rehab.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE HOHMAN REHAB FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Patient Name: _____ Signature_____ Date:_____

PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME:_____ AGE:_____ GENDER: ❑ Female ❑ Male

OCCUPATION:_____ ARE YOU WORKING NOW? ❑ Yes ❑ No

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at all……Mildly optimistic……Fairly……Very optimistic……..Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
12.	List any medications you are taking:		
13.	List all past surgeries with dates:		
14.	List all medical conditions you have (or were told you have):		
15.	What is your:	Height: _____ Weight: _____	
16.	On a scale of 1 to 10, How important is reducing your need for medications?	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
17.	How important is it to you to achieve healthy weight?	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
			Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian):_____ Date: _____

HIPAA Notice Acknowledgement & Consent

Hohman Rehab & Sports Therapy
236 Mohawk Road, Clermont, FL 34711
(352)404-6908
www.hohmanrehab.com

ACKNOWLEDGEMENT

I have received and read the Notice of Privacy Practices for the office **Hohman Rehab and Sports Therapy** and understand my rights contained in the notice.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable

CONSENT

I hereby give my consent for **Hohman Rehab and Sports Therapy** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Hohman Rehab and Sports Therapy** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Katie Hohman, 236 Mohawk Road, Clermont, FL 34715**.

With this consent, **Hohman Rehab and Sports Therapy** may:

- Call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- Contact me by phone, mail, text or email to participate in marketing events, pertinent products or services offered by **Hohman Rehab and Sports Therapy.**
- Use any photos or videos of me to be used for promotional purposes on the internet or within the office.
- E-mail, mail or text message to my home, or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminders, patient billing statements, home exercise programs or reminders and updates from my therapist and their team.
- I have the right to request that **Hohman Rehab and Sports Therapy** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Hohman Rehab and Sports Therapy** to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Hohman Rehab and Sports Therapy** may decline to provide treatment to me.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance.

What is your deductible amount? $_____ and Coinsurance / Copay _____ (for the services you are seeking)

Are there any maximums?

If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.

Patient Name:_____ ID #_____ DOB_____

Insurance Policy 1 Name/Number/Group # (if applicable)_____

_____

***IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?** Give their info here: (otherwise, skip this portion)

- Policyholder Name_____ Date of Birth_____ SSN_____
- Address (if different than Patient)_____
- Relationship to Patient: __ Spouse __ Parent __ Other: _____
- Employer _____ Ph#_____ Claim #_____
- Employer Address _____

Insurance Policy 2 Name/Number/Group # (if applicable)_____

_____

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

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ☐ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____	_____	_____
Signature of Policyholder	Witness	Signature of Claimant, if other than Policyholder