Ability Health Services & Rehabilitation, LP
Patient History Form

Patient Name: ______________________ **D.O.B.:** ____________ **SSN#:**____________________

E-mail Address: ______________________ **Cell/Phone #** ______________________

Age:________ **Sex:** Male Female **Marital Status (please circle):** Single Married Divorced **Religion:** ______________

Emergency Contact Name: ______________________**Phone #:**______________**Relation:**__________

Race: Asian/Pacific Islander_____ Hispanic_____ Black_____ Caucasian______ Eskimo/American Indian_______ Other_______

Ethnicity: Hispanic or Latino____________ Not Hispanic or Latino___________ **Primary Language** __________

Insurance are we billing for services rendered? Commercial____Workers Comp_____ Motor Vehicle_____ Medicare_____ Other__________

Current Problem:______________________**Date of Injury:**______________**Date of Surgery:**______________

Pain level (0-10) Current: _______ **Best:** _______ **Worst:** _______ **Height:** _____________ **Weight:**______________

MEDICAL HISTORY **(Do you have/had any of the following medical conditions?)**

	YES	NO		YES	NO
HEART PROBLEMS?	____	____	PACEMAKER?	____	____
HIGH BLOOD PRESSURE?	____	____	DIABETES?	____	____
TB/HIV/HEPATITIS?	____	____	CANCER?	____	____
SEIZURES?	____	____	PREGNANT?	____	____
URINARY LEAKAGE?	____	____	OSTEOPOROSIS?	____	____
SMOKER?	____	____	ALCOHOL?	____	____

If smoker, how often:______________________ If you drink alcohol, how often:______________________

List any **ALLERGIES**: ____

List all surgeries, injuries, medical problems, or previous therapy that you have had in the past 5 years?
____

List any medical conditions that may affect your therapy: ____

Has your current situation caused any significant difficulty within your family/social life? YES_____ NO_____
If yes, describe: ____

Describe the limitations you have:____

Your goals for therapy:____

Employment/Work: Full-time____ Part-time____ Homemaker____ Student____ Retired____ Unemployed____

Occupation: ______________**Employer:** ______________**Employer Phone:** ______________

Briefly describe your occupation: ____

Do you currently use an Assistive Device? YES____ NO_____

If yes: Cane_____ Walker_____ Rolling Walker_____ Motorized Wheelchair_____ Other: ______________

With whom do you live? Alone_____ Spouse/significant other_____ Child/children_____ relative(s)_____ Group Setting_____

Personal care attendant_____ Other (describe):____

Do you have a Power of Attorney? YES_____ NO_____ Representative: ______________**Phone #** ______________

(Patient Signature):____**Date:**______________

MEDICATION LIST

Patient Name: ____________________________________ DOB: ___________ Date: ________________

Prescription Medication	Reason for Med	Dose	Frequency/Mode	Prescribed by/Phone #:

Over the Counter Medication	Reason for Med	Dose	Frequency/Mode	Prescribed by/Phone #:

Patient Signature: _____________________________ Date:______________________________

ABILITY HEALTH SERVICES & REHABILITATION, LP

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
Ability Health Services, Inc

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, rehab facility, another health care provider, a health plan, and my employer or a health care clearinghouse. This protected health information relates to my past, present, and/or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Ability Health Services is not required to agree to the restrictions that I may request; however, if Ability Health Services agrees to a restriction that I request then the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Ability Health Services has taken action in reliance on this consent.

I understand I have the right to review Ability Health Services Notice of Privacy Practices, which has been made available to me, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and in the performance of health care operations of the Ability Health Services. The Notice of Privacy Practices for Ability Health Services is also posted at each office location and on the Ability Health Services website at **www.abilityrehabilitation.com** This Notice of Privacy Practices also describes my rights and Ability Health Services duties with respect to my protected health information. Ability Health Services reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Ability Health Services website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_______________________________________ _______________________________

Signature of Patient or Personal Representative — Date

_______________________________________ _______________________________

Print Name of Patient — Personal Representative's Authority

I hereby authorize the release of my Protected Health Information to the following individuals (Please Print NAME AND RELATIONSHIP):

____

____

____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this ***Notice of Privacy Practices Acknowledgement***, but was unable to do so as documented below:

Date:	Initials:	Reason:

REVISED 01.01.17

ABILITY HEALTH SERVICES & REHABILITATION, LP

PATIENT GUIDELINES AND CANCELLATION POLICY

1. Please get to your appointments on time in order to allow adequate time for their therapy. Patients arriving late for a scheduled appointment may not get full hour of treatment.
2. Please come appropriately dressed in attire that will allow you comfortable movement of the area to be treated so you are able to perform physical activity such as gym shoes, shorts and t-shirts/tank tops.
3. All patients are required to sign in upon arrival.
4. Food, gum, and drinks other than water are not permitted in the patient treatment areas.
5. Cell phones should be turned off or be on vibrate to avoid disturbing other patients or interrupt treatment.
6. Patients are required to wait in the waiting room areas until they are called in by a clinician.
7. Only the patient is permitted to go in the treatment area. Other adults or children are not permitted in the treatment area unless prior arrangements have been made. Children are never permitted to use any clinical equipment unless they are being treated.
8. A release for treatment must be filled out by any parent that must leave their children under the age of 18 during their therapy session. Children must be picked up promptly following therapy.
9. If you or your child are unable to keep your appointment due to illness or any other reason, please call at least 24 hours in advance to reschedule your appointment. **A cancellation/ no-show fee of $30.00** may be charged.
10. Attending your scheduled therapy sessions is one aspect of your treatment that you can control. In the event of cancellation of less than 24 hours, or you miss your appointment the following policies will apply:

- **First offense**- we will verbally request to follow our cancellation policy.

- **Second offense**- your physician, case manager, and/or insurance company will be notified if you miss your appointment without reasonable cause.

- **Third offense**- inability to schedule with written notification of non-compliance to physician, case manager, and/or insurance company.

Your signature certifies that you have read the Cancellation Policy and accept its terms

____ ______________________

PATIENT/GUARDIAN DATE

____ ______________________

RELATIONSHIP TO PATIENT DATE

Revised: 01.01.17