HO PHYSICAL THERAPY
9675 Brighton Way, Suite 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: _____

HO PHYSICAL THERAPY

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

PLEASE PRINT

PATIENT'S NAME_____ SS#_____ AGE_____

BIRTHDATE(DOB)_____ MARITAL STATUS_____ DRIVER'S LIC#_____

HOME ADDRESS_____ TEL# (____)_____

CITY_____ STATE_____ ZIP_____

PATIENT'S EMAIL_____

PATIENT'S OCCUPATION_____ EMPLOYER_____

BUSINESS ADDRESS_____ TEL# (____)_____

PATIENT'S FINANCIAL RESPONSIBILITY (if this is you, write "self")_____

ADDRESS_____ TEL# (____)_____

NAME OF SPOUSE / PARENT_____ TEL# (____)_____

SPOUSE / PARENT'S EMPLOYER_____ TEL# (____)_____

IN CASE OF EMERGENCY NOTIFY_____ TEL# (____)_____

ADDRESS_____ RELATIONSHIP_____

(Please provide your Insurance Cards and Photo ID to copy)

TYPE OF INSURANCE: MEDICARE _____ PRIVATE _____ AUTO INS _____

PRIMARY INSURANCE NAME_____ POLICY ID#_____

Patient Relationship to Subscriber: SELF____ SPOUSE____ CHILD____ OTHER____

SUBSCRIBER'S NAME_____ SUBSCRIBER'S DOB_____

SECONDARY INSURANCE NAME_____ POLICY ID#_____

Patient Relationship to Subscriber: SELF____ SPOUSE____ CHILD____ OTHER____

SUBSCRIBER'S NAME_____ SUBSCRIBER'S DOB_____

IF THIS IS AN AUTO ACCIDENT INJURY, WE WILL NEED THE FOLLOWING:

AUTO INSURANCE NAME_____ CLAIM#_____

ADJUSTER'S NAME_____ TEL# (____)_____

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

I understand that the payment of all charges incurred is my responsibility and any 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.

I understand that if I am 15 or more minutes late for my appointment, the appointment may be cancelled.

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, Suite 250
Beverly Hills, California 90210
Tel: (310)-278-5337
Fax: (310)-278-6204

Dear Patient:

Ho Physical Therapy is a participating provider with Medicare, Medicare Supplement and Medicare Advantage Plans, we accept the Medicare allowance for our charges. Please be aware that you will be responsible for your annual deductible, the co-insurance, copay and any non-covered services specified by your plan (The deductible for the year 2025 is $257). Keep in mind we will not know what is the patient responsibility until after your insurance has processed your claims; **verification of benefits or coverage is not a guarantee of eligibility or payment. Actual payment is based on terms and conditions of your plan.**

In summary, you are responsible for any deductible, co-insurance, copay or any other patient responsibility indicated by your insurance. **You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services.**

Thank you for choosing Ho Physical Therapy, as your healthcare provider. We value our relationship with you and are grateful for your understanding.

Sincerely,
Ho Physical Therapy

I have read and understand the above statement.

PATIENT'S SIGNATURE **DATE**

HO PHYSICAL THERAPY
9675 Brighton Way, Suite 250
Beverly Hills, California 90210
Tel: (310) 278-5337 Fax: (310) 278-6204

Dear Patient,

According to The Centers for Medicare Services (CMS), only your Home Health Agency (HHA) can bill for medical services while you are enrolled with Home Health Care (HHC). Medicare will not pay for your outpatient physical therapy services if you have not been discharged from the HHA. If your insurance company rejects your services due to HHC it does not relieve you of your financial obligation, balance will be patient responsibility. Therefore, it is very important that you understand the following:

(1) You are responsible for **getting a discharge letter from your HHA** before starting outpatient physical therapy at our clinic.

(2) You do not enroll with a HHA once you have started your treatment with us. Because even with procedures such as blood pressure monitoring, blood work, wound care, nursing, or any home medical services, it will disqualify you from outpatient services. You will then be **responsible for the unpaid claim.**

Thank you for choosing Ho Physical Therapy as your healthcare provider. We value our relationship with you and are grateful for your understanding.

Sincerely,

Ho Physical Therapy

_____ I have been discharged from my Home Health Agency.

_____ I have not received any Home Health Service.

I have read and understand the above statement.

_____

PATIENT SIGNATURE **DATE**

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

We submit claims to your insurance electronically which includes all your information, we need your signature on file for authorization.

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a and 9d.

PATIENT AND INSURED INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SIS

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGN HERE

SIGNED

DATE HERE

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGN HERE

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NUCC b.

33. BILLING PROVIDER INFO & PH. #

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

HO PHYSICAL THERAPY

9675 Brighton Way, Suite 250
Beverly Hills, California 90210
Tel: (310)-278-5337
Fax: (310)-278-6204

January 1, 2025

Dear Patient,

Due to the overwhelming demand of our services and the limited appointments that we have to accommodate all request, we see the need of reinstate & reinforce our Cancellation/ No Show Policy.

- It is very important that you keep your scheduled appointment, and arrive on time.
- A missed appointment will accrue a **$120.00 No Show Fee**.
- This fee can **NOT** be billed to your insurance company, rather, you will be billed directly.
- Payment will be due at the time of your next office visit.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office and we may be able to waive the No Show fee. If your schedule changes and you cannot keep your appointment, please contact us immediately so we can reschedule your appointment.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you might have. We value our relationship with you and are grateful for your understanding.

Good health and good energy to all for 2025!

Sincerely,

Ho Physical Therapy

I have read and understand the Cancellation/ No Show Policy and I acknowledge its terms.

Patient's Signature **Date**