OUTPATIENT REGISTRATION

Please Print

Date: _____

Home Phone: _____

Patient Information

Name: _____ Soc. Sec #: _____

Last First Middle Initial

Address: _____

City/State/Zip: _____

Sex: ☐M ☐F Age: _____ Birthdate: _____ ☐Single☐Married☐Widowed☐Separated☐Divorced

Patient Employed by: _____

Business Address: _____ Phone #:_____

City/State/Zip: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Relationship: _____ Phone #: _____

255 E. Bonita Ave.
P.O. Box 6001
Pomona, CA. 91769-6001
www.casacolina.org

Outpatient Therapy
Phone: 909/596-7733 ext. 3500
Fax: 909/596-6253

Physician Specialty Clinics
Phone: 909/596-7733 ext. 3800
Fax: 909/593-0096
Email: rehab@casacolina.org

CASA COLINA
Hospital and Centers for Healthcare

MEDICAL HISTORY / SUBJECTIVE INFORMATION
Outpatient Services

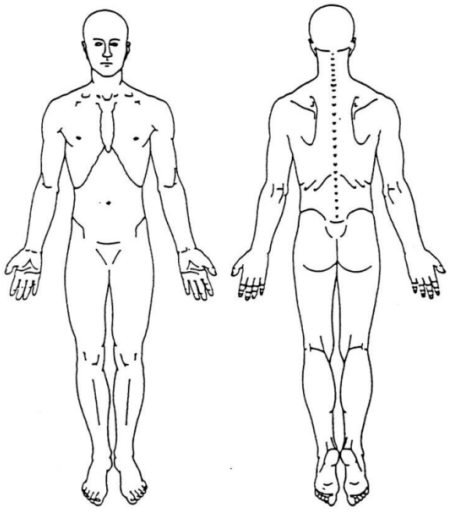
Your Name :				Today's Date:
Date of Birth:	Age:	Height:	Weight:	Do you Smoke? ☐No ☐Yes
Sex: ☐Male ☐Female	If female, are you pregnant? ☐No ☐Yes (if yes, ☐1st Trimester ☐2nd Trimester ☐3rd Trimester)			

Have you ever been diagnosed with the following?

Tuberculosis	☐No	☐Yes	Cancer	☐No	☐Yes	Arthritis	☐No	☐Yes
Diabetes	☐No	☐Yes	Hepatitis	☐No	☐Yes	Stroke	☐No	☐Yes
Heart Condition	☐No	☐Yes	Epilepsy	☐No	☐Yes	Respiratory Problems	☐No	☐Yes
Other: _____				☐No	☐Yes			

Tell us about the condition you came in for today:

1. When did you first notice pain or have functional problems due to the condition/injury? (Specific Date) _____
2. Have you experienced any recent flare ups? ☐No ☐Yes if yes, when? (Specific Date) _____
3. What activities are limited due to this condition/injury? (i.e.: lift, reach) _____
4. When and how did your injury/symptoms occur? ☐Recreation ☐Home ☐Work ☐Auto Accident ☐Unknown ☐Other
5. Have you had a fall in the past 3 months? ☐No ☐Yes
6. Do you feel that you lose balance often? ☐No ☐Yes
7. What do you expect to accomplish with Physical Therapy? _____
8. For this injury, Has your medical care included (check all that apply and answer related questions) :
   a. Surgery: When (Specific Date): _____ What Kind? _____
   b. Injection: When (Specific Date): _____ Did it help? ☐No ☐Yes
   c. Physical Therapy: When _____ to _____ What was done? _____
   d. Chiropractor: When _____ to _____ What was done? _____
   e. Medication(s): _____
   f. Diagnostic Imaging: ☐X-Ray ☐MRI ☐CT Scan ☐Other _____
   g. Exercise: What kind: _____ Did you have any problems? ☐No ☐Yes, explain _____



On the body diagram to the left, please indicate where your symptoms are located at the present time. Use the following symbols to represent where you feel pain and/or numbness. Please do not indicate areas of pain that are not related to your present injury/condition.

● = Pain /// = Numbness

Please answer the following questions about your symptoms:

1. Are your symptoms: ☐Constant ☐Intermittent
2. Are they: ☐Getting Better ☐Getting Worse ☐Staying the Same
3. What makes your symptoms better? _____
4. Rate your pain using a pain scale (0=No Pain; 10= Most Extreme Pain):
   Worst pain rating: _____ Best pain rating: _____

CASA COLINA
Hospital and Centers for Healthcare

PATIENT SUMMARY LIST

Outpatient Services

Patient Name: _____ Date: _____

Do you have **Diabetes**? ☐ Yes ☐ No
If YES, have you been hospitalized or been admitted to the emergency room in the last 6 months due to high or low blood sugar? ☐ Yes ☐ No

Known **Diagnosis** and **Conditions**:

_____ _____
_____ _____

Known Significant **Surgical** and **Invasive Procedures:**

_____ _____
_____ _____

Known **Allergic Drug Reactions**:

_____ _____
_____ _____

Known **Medications**:

Medication(s)	Dose	Frequency	Current (✓)	Date Started	Date Discontinued

History of resistant bacteria: ☐ Yes ☐ No If YES, notify infection control nurse
History of immunizations: ☐ Current ☐ Copy provided ☐ Opt out ☐ If Opt out, see form

Updated by: _____ Date: _____ Time:_____ _____ Date: _____ Time:_____
_____ Date: _____ Time:_____ _____ Date: _____ Time:_____
_____ Date: _____ Time:_____ _____ Date: _____ Time:_____
_____ Date: _____ Time:_____ _____ Date: _____ Time:_____
_____ Date: _____ Time:_____ _____ Date: _____ Time:_____

Patient Information Sticker

Casa Colina Hospital
Outpatient Center

Missed Appointment and Late Policy

Here at Casa Colina's Outpatient Center each patient is important to us and for this reason *we request that patients do their best to attend all scheduled appointments.* We realize that occasionally an appointment needs to be cancelled and we request that all cancellations be made at least 24 hours in advance of the appointment time.

Cancelled or Missed Appointments: If you cancel your appointment within 24 hours or no-show for an appointment you will be charged a $10.00 fee. A pattern of poor attendance over the course of your treatment will result in the cancellation of your future appointments. You may need to return to your physician before additional appointments are scheduled. A new prescription for services may be required. _____
Initial

In some cases there will be a charge for missed appointments regardless of cancellation notification.

Late Appointments: If you arrive late for a therapy session, every attempt will be made to accommodate you. However, the appointment may be rescheduled to the next available opening on the therapists' schedule. If you arrive 15 minutes late or later for a 30 or 45 minute therapy appointment, or 30 minutes late for a 60 minute therapy appointment you may be given the option of attending the remainder of the treatment or rescheduling to another time (all applicable co-payments and cancellation fees will apply regardless of length of treatment).

Thank you for choosing Casa Colina Outpatient Center. We appreciate your understanding and cooperation in achieving our mutual goal of maximizing the benefits of your outpatient therapy.

Outpatient Operations

_____ _____

Patient /Guardian Signature Date

CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE CONDITIONS OF ADMISSION FOR OUTPATIENT SERVICES

For the purposes of this document, the term "patient" or "I" means the patient, the patient's legal representative (e.g. parent, conservator, guardian, healthcare power of attorney), or residential clients of Casa Colina Hospital and Centers for Healthcare (hereafter referred to as Casa Colina).

CONSENT TO MEDICAL, THERAPY, AND SURGICAL PROCEDURES

I consent to the procedures that may be performed during this episode of care or while I am an outpatient. These may include, but are not limited to emergency treatment or services, laboratory procedures, X-ray examinations, medical, therapy, or services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and therapies is not an exact science and that diagnosis, treatment, and therapies may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination, treatment, or therapy in Casa Colina.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

All physicians providing services to me, including the radiologist, have been granted the privilege of using Casa Colina for the care and treatment of patients, but they are not employees, representatives or agents of Casa Colina. They are independent practitioners. These physicians will bill separately for their services.

Patient initials: _____

I understand that I am under the care and supervision of my attending physician. Casa Colina and its therapy and other clinical staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, for medical, special diagnostic or therapeutic procedures, or services provided to me under my physician's general and special instructions.

Patient Label or
Patient Name:
MR#:

Account #:

FINANCIAL AGREEMENT

I agree to promptly pay all Casa Colina bills I incur in accordance with the charges listed in Casa Colina's chargemaster and, if applicable, Casa Colina's charity care and discount payment policies and state and federal law. I understand that I may review Casa Colina's chargemaster before (or after) I receive services from Casa Colina. I understand that all physicians including the radiologist, will bill separately for their services. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.
Patient initials: _____

ASSIGNMENT OF ALL RIGHTS AND BENEFITS

The undersigned authorizes, whether he/she signs as an agent or as the patient, assignment and transfer to Casa Colina all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to Casa Colina of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. The undersigned agrees that the insurer or plan's payment to Casa Colina pursuant to this authorization shall discharge its obligations to the extent of such payment. The undersigned understands that he/she is financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. The undersigned agrees to cooperate with, and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment.

HEALTH PLAN CONTRACTS

Casa Colina maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Inpatient Admissions office, the outpatient registration area, or on the Casa Colina website at casacolina.org. All physicians and surgeons, including the radiologist, pathologist, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if Casa Colina or the physicians providing services to me contract with my health plan. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to the patient by Casa Colina if the patient belongs to a plan that does not appear on the above mentioned list.

FINANCIAL ASSISTANCE

If you do not have insurance coverage, you MAY qualify for financial assistance. Casa Colina Hospital and Centers for Healthcare has a program to assist uninsured low income patients with discounted or charity care for Casa Colina services. Casa Colina may also agree to assist with setting up payment plans for those persons needing this type of assistance. For more information regarding your eligibility

Patient Label or
Patient Name:
MR#:

Account #:

for financial assistance, or for setting up a payment plan, please ask the Admissions or Registration Department staff for assistance, or call the Director of Patient Accounting at (909) 596-7733 Ext. 2166 or Ext. 3254.

CHARGEMASTER

To provide you with information you need to make healthcare decisions, Casa Colina makes available to you Chargemaster information. The Chargemaster is a comprehensive list of all services, supplies, and procedures offered at Casa Colina Hospital and Centers for Healthcare, along with their corresponding charges. This is the master list used to create a patient's bill. Our Chargemaster is available for your review by appointment in our Patient Financial Services Department. Estimate of your bills are available upon request. Please contact Patient Financial Services for assistance at (909) 596-7733 Ext. 2166 or 3254.

CONSENT TO PHOTOGRAPH

I hereby consent to be photographed while receiving treatment at Casa Colina. The term **"photograph"** as used herein, includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I understand that the images from such photography may be used for my diagnosis, treatment, or therapy, or for Casa Colina's health care operations such as training and education programs, peer review or medical education, as my treating physician(s) or other clinical staff deem appropriate.

Photography for other purposes such as research, publication, outside education, marketing, public relations, or news or documentary requires an additional consent form be obtained.

PARTICIPATION IN EDUCATION PROGRAMS

Unless Casa Colina is notified to the contrary in writing, as part of the health education program of this institution, residents and students associated with approved affiliated programs may observe or participate in patient care or in activities that support patient care. These individuals may be present during treatments and procedures and may perform limited services under the supervision of Casa Colina physicians or other qualified persons for supervision of their activities.

Patient Label or
Patient Name:
MR#:

Account #:

Information on Quality of Care

Online resources are available to you concerning the quality of care provided by hospitals and healthcare systems nationwide.

Joint Commission on Accreditation of Healthcare Organizations
http://www.qualitycheck.org/

Hospital Compare
http://www.hospitalcompare.hhs.gov

HealthGrades
http://www.healthgrades.com

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

By initialing this section, I acknowledge receipt of the "Notice of Privacy Practices" of Casa Colina. The "Notice of Privacy Practices" explains how Casa Colina may use and disclose my protected health information. Casa Colina encourages me to read it in full.

Casa Colina may change the "Notice of Privacy Practices". If the notice should change, I may obtain a copy of the revised notice by:

- Accessing Casa Colina's website at www.casacolina.org; or
- Contacting the Admissions Department at (909) 596-7733 or toll free (866) 724-4127 ext. 3900; or
- Contacting the Outpatient Services Department at (909) 586-7733 or toll free (866) 724-4127 ext. 3500; or
- Contacting Casa Colina's Privacy Officer at (909) 596-7733, ext. 3410

Patient initials: _____

If it is not possible to obtain the patient or the patient's representative's Acknowledgement for the receipt of the Notice of Privacy Practices, describe the good faith efforts made to obtain the individual's Acknowledgement, and the reasons why the Acknowledgement was not obtained:

☐ *Patient refused to sign this Acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices*

☐ *Other:*_____

_____

Patient Label or
Patient Name:
MR#:

Account #:

*Date:*_____ *Time:*_____ *AM/PM*

*Signature:*_____
(Provider Representative)

*Print Name:*_____
(Provider Representative)

I certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or I am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship:

Print name:_____
(legal representative)

Signature: _____
(witness)

Print name: _____
(witness)

Original: Health Record
Copies: Patient (or whoever has signed the form)
Person financially responsible (if other than the patient or whoever signed the form)

Patient Label or
Patient Name:
MR#:

Account #:

CASA COLINA
Hospital and Centers for Healthcare

OPPORTUNITY FOR PATIENT TO OBJECT TO USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR CERTAIN PURPOSES

Patient's Name: _____

Address: _____

City: _____ **State:** ___ **Zip Code:** _____

Home Telephone: _____ **Date of Birth:** _____

I understand that **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE** has a Notice of Privacy Practices (the "Notice"). I hereby acknowledge that by my review of the Notice and this form, **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE** has informed me that my health information may be used or disclosed for one or more of the four purposes described below.

I further understand that **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE** will not disclose any of My Highly Confidential Health Information (as defined herein) pursuant to this Permission Form. "**My Highly Confidential Health Information**" includes psychotherapy notes and the subset of Protected Health Information that is related to:

(1) treatment of mental health and developmental disabilities; (2) alcohol and drug abuse prevention and treatment; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic and elder abuse; or (8) sexual assault.

PURPOSES:

1. **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE's** Directory. Use of the following pieces of Protected Health information about me to maintain a directory of individuals in Casa Colina's Inpatient, Ambulatory Surgery, Observation, and Residential facilities and disclosure of such information for directory purposes to members of the clergy and persons who ask for me by name.
   a. my name;
   b. my location in **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE;**
   c. my condition described in general terms that do not communicate specific medical information; AND
   d. my religious affiliation (which information may only be disclosed to members of the clergy).
2. For Involvement of Others in My Care. Disclosure of my Protected Health Information to a family member, other relative, close personal friend, domestic partner, significant other or any other person identified by me, that is directly relevant to that person's involvement with my care or payment for my care.
3. For Notification of My Location, General Condition or Death. Disclosure of my Protected Health Information to notify (or assist in the notification of) persons as identified in #2 above, of my location, general condition or death.
4. For Disaster Relief Efforts. Disclosure of my Protected Health Information to a public or private entity authorized to assist in disaster relief efforts in order to coordinate efforts to notify (or assisting in the notification of) those listed in #2 of my location, general condition or death.

Shared
Opportunity to Object to PHI Disclosures
1008

CASA COLINA
Hospital and Centers for Healthcare

OPPORTUNITY FOR PATIENT TO OBJECT TO USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR CERTAIN PURPOSES

5. In addition, the inpatient rehabilitation program utilizes schedule boards to provide patients, families, therapists, nursing, and other patient care personnel with information to assist patients in knowing their schedule for attendance at therapy sessions. This board is posted in the Rehabilitation units and includes the disclosure of the name ofthe patient.
6. Casa Colina Hospital has collaborated with CommonWell to offer accessibility to the HealthInformation Exchange (HIE). CommonWell is a not-for-profit trade association; devoted to the visionthat health data should be available to individuals and caregivers regardless of where care occurs.The HIE connects the health care community and enables the sharing of information electronicallyand securely to improve quality ofhealth care services.

I acknowledge that CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE has provided me with the opportunity to:

1) agree to the uses or disclosures described above;
2) request restrictions on some of these uses or disclosures; or
3) prohibit these uses or disclosures.

By my signature below, I hereby agree to the following
(Please check <u>one</u> of the boxes below):

☐ the use and disclosure of my health information for all of the six purposes described above.

☐ the use and disclosure of my health information only for the following purposes.
(Please check the applicable purpose(s)):

☐ 1 (Facility Directory)
☐ 2 (Involvement of Others in My Care)
☐ 3 (Notification of My Caregiver)
☐ 4 (Disaster Relief Efforts)
☐ 5 (Schedule Boards for inpatient programs only)
☐ 6 (Enroll in CommonWell for Health Information Exchange only)

☐ The use and disclosure of my health information for all of the six purposes described above, subject to the following restriction(s):

☐ By my signature below, I hereby prohibit the use and disclosure of my health information for all of the above listed purposes.

Printed Name of Patient or Authorized Representative

Relationship | Patient Signature or Authorized Representative | Date/Time

Shared
Opportunity to Object to PHI Disclosures
1008