327 Main Street
El Segundo, California
United States, 90245
Phone: 310-725-8505
www.pacificphysicaltherapy.com

Patient Information

Patient's Demographics:

Name:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone- Home: ( )____-_____ Work: ( )____-_____ Cell: ( ) ____-_____

Date of Birth: _____ E-Mail _____

Sex: (Male)_____ (Female)_____ Height:_____ Weight:_____

Employer: _____ Occupation:_____

Spouse or Parent/Guardian:

Name: _____ Relationship to Patient: _____

Address: _____

Employer: _____ Business Phone: ( )_____-_____

IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT: _____

Phone: ( ) _____ - _____

DATE OF INJURY OR ONSET OF PAIN: _____/_____/_____

SURGERY: _____/_____/_____

Area(s) of pain and area(s) to be treated:_____

How did you hear of Pacific Physical Therapy?

PACIFIC
PHYSICAL THERAPY

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Assignment of Benefits

Patient's Name: _____

Occasionally, payment for treatment is sent to the patient instead of Pacific Physical Therapy. Please know that should this occur, you are responsible for all payments directly received from the insurance company. Please bring in the payment at your next visit. If treatment has concluded, you may mail in the payment or drop it off during working hours.

While Pacific Physical Therapy has pre-verified your benefits, there are times when additional money may be owed. Should your insurance company deny any/all payment for treatment, you will be held financially responsible for any outstanding balance. Payment is to be made immediately to Pacific Physical Therapy, upon request.

I hereby authorize Pacific Physical Therapy to furnish my insurance carrier(s) any and all requested information concerning my health care. **I also authorize my insurance carrier(s) to pay Pacific Physical Therapy directly for services rendered.**

Office Use Only

Patient's Identification Number: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

Signed: _____ Date: _____
(Patient or Legal Guardian)

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Office Policies

Appointments/Cancellations

Keeping your scheduled appointments are very important to your physical therapy program. To avoid incurring any unnecessary charges a 24 hour advanced notification is required for all changes and cancellations. Cancelling an appointment within 24 hours of your scheduled appointment will result in an $85.00 cancellation fee (not billable to insurance).

Insurance

At Pacific Physical Therapy, we want to do everything we can to make your therapy experience as smooth and worry free as possible. If you have any further questions regarding your benefits please feel free to ask at the front desk.

Prescriptions

In order to continue to bill your insurance company for our physical therapy, it will be necessary to have a current prescription from your doctor. While we will remind you when you need to obtain new prescription, ultimately it is your responsibility. Not having a current prescription on file may result in a delay of treatment as well as a large financial payment that you will be responsible for.

_____ _____

Patient Signature Date

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Notice of Privacy Practices

We protect the privacy of our patient's health information by law, practice standards, and our internal policies and procedures. This privacy statement explains your rights, our legal duties, and our privacy practices.

Your Health Information
THIS NOTICE DESCRIBES YOUR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We collect, use, and disclose information provided by and about you for medically necessary treatment, health care payment and operations or when we are otherwise permitted or required by law to do so.

For Treatment: We may use and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers, and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.

For Payment: We may use and disclose information about you in managing your medical file, to secure treatment authorization, to confirm insurance coverage, for medical billing and receiving payments for medical care through your health plan or other similar entities. We may also provide information to a doctor's office, hospital, or other health care providers or health plans to confirm your eligibility for benefits, medical diagnosis, treatment, and other medically necessary information in order to provide appropriate services and receive payment.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about your to review the quality of care and services you receive; to provide you medical file management or coordination of medical services such as between treating therapists or between doctor and therapist.

As Permitted or Required by Law: Information provided by you may be used or disclosed to regulatory agencies, such as during audits, licensure, or other proceedings; for administrative or judicial proceedings; to public health authorities; or to law enforcements official, such as to comply with a court order or subpoena.

Authorization: Other used and disclosures of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. We will then stop using your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Your Rights Under regulations that will be in effect on April 14, 2003, you will have additional rights over your health information. Under the new rules, you will have the right to:

- Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.
- Request that we communicate with you about medical matters using reasonable alternative mean or at an alternative address if communications to your home address could endanger you.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment, or healthcare operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14, 2003.

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Complaints
If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copies and Changes
You have the right to receive an additional copy of this notice at any time. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

Contact Information
If you want to exercise your rights under this notice or if you wish to communicate to us about privacy issues or to file a complaint with us, please contact or privacy officer at: 310-648-3167.

Declaration of Privacy of Health Information
All medical records and other individual identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the US Department of Health and Human Services (HHS), and are covered by HIPPA (Health Insurance Portability and Accountability Act of 1996).

Further, I authorize that the results of any assessments or records given to me may be used in completing evaluations, assessments, treatment plans, progress reports, summary reports, discharge summary reports and medical billing and reimbursement. I understand that such reports will only report aggregated data, and will only be used for health care purposes such as third party payment and physician or other authorized health care provider treatment or progress reports. I understand I can restrict the uses and disclosures of my medical information. I understand that I have the right to file a formal complaint with a covered provider or health plan or HHS about violations regarding my health and medical records or information.

This release is and shall be binding upon my heirs, assigns, executors, and administrators.

Restrictions requested by patient:

_____

_____

Signature of Patient: _____ Date: _____

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Health Questionnaire

Name: _____ Date: _____

Medical History

Allergies	□Yes □No	Depression	□Yes □No	Incontinence	□Yes □No
Anemia	□Yes □No	Diabetes	□Yes □No	Metal Implants	□Yes □No
Anxiety	□ Yes □No	Dizzy Spells	□Yes □No	Multiple Sclerosis	□Yes □No
Arthritis	□Yes □No	Emphysema/Bronchitis	□Yes □No	Osteoporosis	□Yes □No
Asthma	□Yes □No	Fibromyalgia	□Yes □No	Parkinson's	□Yes □No
Cancer	□Yes □No	Fractures	□Yes □No	Seizures	□Yes □No
Cardiac Conditions	□Yes □No	Heart Disease	□Yes □No	Strokes	□Yes □No
Cardiac Pacemaker	□Yes □No	Hepatitis	□Yes □No	Thyroid Disease	□Yes □No
Currently Pregnant	□Yes □No	High Blood Pressure	□Yes □No	Vision Problems	□Yes □No

HEIGHT: _____ **WEIGHT:** _____

Fall History

Injury as a result of a fall in the past year? □Yes □No Date of Fall: _____

Two or more falls in the last year? □Yes □No Date of Falls: _____

Surgical History

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Current Medications (Including OTC, Herbals & Supplements)

Drug: _____ Dosage/Frequency: _____ Reason: _____ By mouth? □Yes □No

Drug: _____ Dosage/Frequency: _____ Reason: _____ By mouth? □Yes □No

Drug: _____ Dosage/Frequency: _____ Reason: _____ By mouth? □Yes □No

Drug: _____ Dosage/Frequency: _____ Reason: _____ By mouth? □Yes □No

Drug: _____ Dosage/Frequency: _____ Reason: _____ By mouth? □Yes □No

Drug: _____ Dosage/Frequency: _____ Reason: _____ By mouth? □Yes □No

Drug: _____ Dosage/Frequency: _____ Reason: _____ By mouth? □Yes □No

Sports and Leisure Activities: _____

_____

PACIFIC PHYSICAL THERAPY

Marketing Survey

Pacific Physical Therapy would like to know how you found out about us.
Please place a check mark on all that apply & fill in the information. Thank you.

○ 

Medical Referral

(Please write the Physician's or Nurse Practitioner's name in the space provided)

○ **Patient Referral**

(Please write person's name in the space provided.)

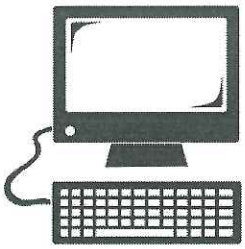
○ 

Print Advertisement

(Please write name of publication in the space provided.)

○ **Web Search Online**

Did you visit our website? Yes No



How helpful was the website at helping you make the decision to have Pacific Physical Therapy be your physical therapy provider? (please rate from 1 to 5, 5 being the highest)

1 2 3 4 5

○ 

(Please let us know in the space provided.)

_____