PACIFIC PHYSICAL THERAPY & SPORTS REHABILITATION
HERMOSA BEACH

PATIENT INFORMATION

Patient Name: _____

Address: _____

_____

Telephone: Home_____Cell_____ Work_____

E-mail address: _____

Birthdate: _____ Gender: Male_____ Female_____

SS#: _____

Employer: _____

Occupation: _____

Name of Spouse (or Legal Guardian):_____

Emergency Contact/Telephone#:_____

We like to thank individuals who refer patients to our facility. How/where did you hear of us? _____

_____

INSURANCE INFORMATION

The Front Office Personnel will make a copy of your insurance card for your file, however, if the insurance is under someone else's name please provide us with the following:

Insured's Name: _____
Birthdate: _____SS#_____
Telephone #: _____
Employer/Address: _____
_____

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PATIENT HISTORY

Please complete this form completely. This will assist us in properly treating you and identifying possible contraindications for certain treatments. All information provided is held in strict confidence.

Name:_____

Date: _____Date of Injury:_____Date Last Worked:_____

Briefly describe how you were injured or how complaints began (i.e., after gardening, lifting, while working, etc…):_____
_____

Where is your pain/injury located?:_____
_____

List all over-the-counter & prescription medications you are currently taking for any reason:_____
_____

If you have any metal implants in your body, please describe where they are:
_____
_____

Have you had physical therapy before for this condition?:_____

Have you had any of the following diagnostic studies completed for this condition?

____EMG (Electromyograph) ____Arthrogram
____EEG (Electroencephalograph) ____X-Rays
____Myelogram ____MRI
____C.T. SCAN (Computed Tomography/Delta Scan
____Other (describe)_____

Have you ever been under the care of a physician for any of the following reasons?

____Kidney Disease ____Heart Disease ____Respiratory
____Headaches ____Eye/Vision Problems ____Diabetes
____Arthritis ____Allergies ____Pregnancy
____Cancer/Tumors ____Alcohol/Drugs ____Sleep Problems
____Other (describe)_____

Signature_____Date:_____

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PATIENT NAME: _____

Consent for Care and Treatment

I hereby agree and give my consent for Pacific Physical Therapy to furnish care and treatment necessary considered necessary and proper in treating my condition.

Verification of Insurance Coverage

As a courtesy to our patients, we will verify your insurance coverage and review your benefits. It is your responsibility to be aware of any limits or exclusions to your coverage. ***Verification of coverage is not a guarantee of payment and we are not responsible if the information provided is incorrect.***

Financial Responsibility and Assignment of Benefits

I am responsible for any unpaid balance, regardless of any insurance coverage. I assign all medical benefits to which I am entitled to be paid directly to Pacific Physical Therapy. In the event payment is made directly to me, I recognize I have an obligation to promptly remit payment to this office. If it becomes necessary to commence legal action, I am responsible for all costs incurred, including collection agency fees, attorney fees, and court costs.

Deductibles, Copays, and Coinsurances

I understand that payment is due at the time of service, unless prior financial arrangements have been made.

Cancellation Policy

Specific time is reserved for you when you schedule an appointment. If you cannot keep your appointment, we require at least 4 hours notice. We have a 24 hour answering machine for your convenience. If you do not show or cancel with less than 4 hours notice, you will be charged a fee of $40.00. This charge will not be billed to your insurance and is your responsibility. If there are 3 occurrences, you will no longer be able to schedule in advance.

Release of Information

I hereby authorize Pacific Physical Therapy to release any information necessary relating to my health care claims.

I have read and fully understand all of the above information and agree to comply as outlined above.

_____ _____

Patient or Guardian Signature ***Date***

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NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

PACIFIC PHYSICAL THERAPY'S LEGAL DUTY

Pacific Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Pacific Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. Pacific Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, Pacific Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Pacific Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Pacific Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Pacific Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Pacific Physical Therapy's health information practices, or if you have a complaint, please contact the following person:

Christine Spryer, Owner
Pacific Physical Therapy
2615 Pacific Coast Hwy, Suite 321
Hermosa Beach, CA 90254
Telephone: 310-798-6310 Fax: 310-798-6312
EFFECTIVE APRIL 11, 2017

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PATIENT ACKNOWLEDGEMENT OF INFORMATION

I have read and fully understand Pacific Physical Therapy's Notice of Information Practices. I understand that Pacific Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operation related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Pacific Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

_____

Patient Name

_____

Patient Signature

_____

Date

PACIFIC PHYSICAL THERAPY & SPORTS REHABILITATION

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all if the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment at Pacific Physical Therapy. I understand the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date