

# **Patient Information and Treatment Authorization**

Address: 424 E NUEVO ROAD  City, Zip: PERRISCA92570  Home Ph: (951)987-6526  Work Ph: Cell Ph:  PATIENT INFORMATION #  Date: 05/01/2022  Type: WC  REFERRING DOCTOR INFORMATION  Name: GANSERT, KEVIN  Address: 601 N EUCLID AVE  City, Zip: ONTARIOCA91762  Phone: (626)852-2268  ATTORNEY INFORMATION  Name: City, Zip:  EMPLOYMENT INFORMATION:  Name: City, Zip:  PRIMARY INSURANCE INFORMATION  Name: Address: Adj/Ph#: Type: Ins Name: Pol#/Clm#:  RELEASE OF INFORMATION and ASSIGN  I hereby authorize WestStar Physical Therapy concerning this illness upon request. I hereby Physical Therapy for services rendered.	Date Sig	gned
City, Zip: PERRISCA92570  Home Ph: (951)987-6526  Work Ph: Cell Ph: PATIENT INFORMATION #  Date: 05/01/2022  Type: WC  REFERRING DOCTOR INFORMATION  Name: GANSERT, KEVIN  Address: 601 N EUCLID AVE  City, Zip: ONTARIOCA91762  Phone: (626)852-2268  ATTORNEY INFORMATION  Name: City, Zip: EMPLOYMENT INFORMATION:  Name: City, Zip: PRIMARY INSURANCE INFORMATION  Name: Address: Adj/Ph#: Type: Ins Name: Pol#/Clm#: RELEASE OF INFORMATION and ASSIGN I hereby authorize WestStar Physical Therapy concerning this illness upon request. I hereby	05/30/23	
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City, Zip:		requested by my insurance carrier
City, Zip:		
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City, Zip: PERRISCA92570  Home Ph: (951)987-6526  Work Ph: Cell Ph:  PATIENT INFORMATION #  Date: 05/01/2022  Type: WC  REFERRING DOCTOR INFORMATION  Name: GANSERT, KEVIN  Address: 601 N EUCLID AVE  City, Zip: ONTARIOCA91762  Phone: (626)852-2268  ATTORNEY INFORMATION  Name: City, Zip: EMPLOYMENT INFORMATION:	Phone:	
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City, Zip: PERRISCA92570  Home Ph: (951)987-6526  Work Ph: Cell Ph: PATIENT INFORMATION #  Date: 05/01/2022  Type: WC		
City, Zip: PERRISCA92570  Home Ph: (951)987-6526  Work Ph: Cell Ph: PATIENT INFORMATION #  Date: 05/01/2022		
City, Zip: PERRISCA92570  Home Ph: (951)987-6526  Work Ph: Cell Ph: PATIENT INFORMATION #	Sx Date:	
City, Zip: PERRISCA92570  Home Ph: (951)987-6526  Work Ph: Cell Ph:	Post Sx:	
City, Zip: PERRISCA92570  Home Ph: (951)987-6526  Work Ph:		
City, Zip: PERRISCA92570  Home Ph: (951)987-6526		
City, Zip: PERRISCA92570	Email:	
	Age:	25
Address: 424 E NUEVO ROAD	DOB:	01/03/1998
	Sex:	F
Name : ZELINDA ARELLANO	SSN:	XXX-XX4481



# **JOB INFORMATION #**

Name: ZELINDA ARELLANO  SSN: XXXXX4481  JOB INFORMATION #  Job Title:	PATIENT #							
ADDITIONAL JOB DETAILS  During a typical 8-hour day, How many hours do you?  Si: Hours Squating: Hours  Stand: Hours Stooping/bending: Hours  Walk: Hours Reaching Up: Hours  At work, on average, how many hours do you work  Per Hours Reaching Up: Hours  At work, on average, how many hours do you work  Per Twisting: Hours  Week: Hours Crawling: Hours  Stair Climbing: Hours  Using a Computer: Hours  At work, my job requires that I lift Constantly Often Sometimes Never  To libs to 125 lbs: 26 lbs to 50 lbs: 11 lbs to 25 lbs: 26 lbs to 50 lbs: 15 lbs to 75 lbs: 15 lb	Name:	ZELINDA ARELLAI	NO		SSN:	XXX-XX4	481	
ADDITIONAL JOB DETAILS  During a typical 8-hour day, How many hours do you?  Si: Hours Squating: Hours  Stand: Hours Stooping/bending: Hours  Walk: Hours Reaching Up: Hours  At work, on average, how many hours do you work  Per Hours Reaching Up: Hours  At work, on average, how many hours do you work  Per Twisting: Hours  Week: Hours Crawling: Hours  Stair Climbing: Hours  Using a Computer: Hours  At work, my job requires that I lift Constantly Often Sometimes Never  To libs to 125 lbs: 26 lbs to 50 lbs: 11 lbs to 25 lbs: 26 lbs to 50 lbs: 15 lbs to 75 lbs: 15 lb								
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ADDITIONAL JOB DETAILS  During a typical 8-hour day, How many hours do you?  Sit:	Ich Decerintie							
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Ladder Climbing:  Using a Computer:  Hours  Hours  Hours  Pushing:  Pulling:  Lifting Overhead:  Hours  Hours  Hours  Hours  Hours  Hours  Hours  Pulling:  Lifting Overhead:  Hours  At work, my job requires that I lift  Constantly  Often  Sometimes  Never  10 lbs or less:  11 lbs to 25 lbs:  26 lbs to 50 lbs:  51 lbs to 75 lbs:  76 lbs to 100 lbs:  over 100 lbs:  At work, my job includes  Constantly  Often  Sometimes  Never  Repetitive Hand Movement:  Repetitive Foot Movement:  Power Gripping:  Precision Handling:  Balancing:  Use of computer mouse/touch pad:  Timed work for efficiency:					Stair Climbing :			Hours
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			}		{	}		{
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# **INJURY INFORMATION**

PATIENT #	ŧ					
Name:	ZELINDA ARELLAN	10	SSN:	XXX-XX4481		
INJURY IN	FORMATION #					
Briefly descri	be your injury :					
					Yes	No
Did you go	to the Emergency Ro	oom at a Hospital?				
If not an En	nergency Room, Ad	you go to some other ty	pe of medical	facility?		
Were x-rays	s taken?					
If an auto ac	ccident, was the vehi	cle drivable after the acc	cident?			
Do you hav	e any previous injury	to the sense area?				
Are you stil	l being treated for th	is injury?				
If you are st	till being treated for t	his injury, by whom?				
Name:						
Address:						
City, Zip:						
Phone						



### **PAIN INFORMATION**

Document Date: 05/30/23

### PATIENT #

Name: ZELINDA ARELLANO SSN: XXX-XX4481

### PAIN INFORMATION #

Draw the location of your pain on the body outlines using the following markers.

A = Achesches

B = Burning

N = Nurnbness

P = Pins & Needles

S = Stabbing

0 = Other







Document Date: 05/30/23

PATIENT #					
Name:	ZELINDA ARELLANO	SSN:	XXX-XX4481		

#### WAIVER INFORMATION

I, AM OF LEGAL AGE AND HEREBY CERTIFY THAT I WENT TO WEST STAR PHYSICAL THERAPY OF MY OWN DISCRETION AND DECISION TO RECEIVE PHYSICAL THERAPY TREATMENTS. I UNDERSTAND THAT I MAY OR MAY NOT HAVE A DOCTORS REFERRAL AND THAT GETTING PHYSICAL THERAPY IS MY TREATMENT OF CHOICE. I ALSO UNDERSTAND THAT I WILL BE EVALUATED BY A LICENSED AND CERTIFIED PHYSICAL THEREAPIST AND THAT THE THERAPISTS EVALUATION AND RECOMMENDATION WILL BE EXPLAINED TO ME BEFORE TREATMENT. I UNDERSTAND THAT THE PHYSICAL THERAPIST WILL COMMUNICATE WITH MY MEDICAL DOCTOR TO GET AUTHORIZATION FOR MY PHYSICAL THERAPY TREATMENTS. I ALSO UNDERSTAND THAT I CANNOT RECEIVE PHYSICAL THERAPY TREATMENTS FROM WEST STAR PHYSICAL THERAPY WITHOUT SIGNED AUTHORIZATION FROM MY MEDICAL DOCTOR. FURTHERMORE, I UNDERSTAND THAT PHYSICAL THERAPY, WHILE DESIGNED TO, IS NOT GUARANTEED TO IMPROVE MY CURRENT CONDITION.

#### **IF MINOR:**

NAME OF PARENT OF GUARDIAN:	
RELATIONSHIP:	
PATIENT SIGNATURE:	
Date	
WITNESSED BY:	
NAME OF STAFF MEMBER:	
SIGNATURE:	
Date	



Document Date: 05/30/23

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Name:	ZELINDA ARELLANO	SSN:	XXX-XX4481

### **PRIVACY INFORMATION** Page (1 of 3)

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For Example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

#### Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For Example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, services provided and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities of and management of West Star Physical Therapy. For Example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement: your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Public Health Reporting: Your health care information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states public health department.

Other Uses and Disclosures That Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific, written authorization. However, your decision to revoke authorization will not affect of undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.



Document Date: 05/30/23

PATIENT #						
Name:	ZELINDA ARELLANO	SSN:	XXX-XX4481			
PRIVACY	INFORMATION Page (2 of 3)					
Appointme	ent Reminders: Your health informati	ion will be used by ou	ar staff to send you appointment r	eminders.		
interesting	on About Treatments: Your health info on the treatment and management of on describing only West Star related in	f your medical condit	on. From our database, we may a	*		
	Please do not use my health	n information for the	above-mentioned services.			

Individual Rights: You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health care information;

The right to receive confidential communications concerning your medical condition and treatment;

The right to inspect and copy your protected health information;

The right to amend or submit corrections to your protected health care information;

The right to receive an accounting of how and to whom your protected health information has been disclosed;

The right to receive a printed copy of this notice

West Star Physical Therapy Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend to modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visits. The revise policies and practices will be applied to all protected health information we maintain.



Document Date: 05/30/23

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Name:	ZELINDA ARELLANO	SSN:	XXX-XX4481

### **PRIVACY INFORMATION**Page (3 of 3)

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information we maintain. As permitted by Federal Regulations we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our corporate office. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

West Star Physical Therapy PO BOX 6209 Garden Grove, CA 92846

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The address of the person you may contact for further information consenting privacy practices is:

West Star Physical Therapy PO BOX 6209 Garden Grove, CA 92846

Effective Date: This notice is effective as of May 18, 2012



PATIENT	#		
Name:	ZELINDA ARELLANO	SSN:	XXX-XX4481
PRIVACY	ACKNOWLEDGMENT INFORMATION		
acknowled	Acknowledgement of Receipeived, read and fully understand the Notice of a lge and understand that West Stat Physical the outlined in the notice.	f Privacy Pr	actices for West Star Physical therapy and
	Patient : SIGNATURE:_ Date_		
Patient Re	Relationship to Patient :_		is an adult who is unable to sign this form.