

Patient Information and Treatment Authorization

Document Date: 05/03/23 PATIENT INFORMATION # WESTSTAR SAN BERNARDINO SHAWNEE MURRAY XXX-XX9999 Name: SSN: Address: 14993 CHRISTOPHER ST Sex: ADELANTOCA92301 09/04/1972 City, Zip: DOB: 50 (323)997-6545 Home Ph: Age: Work Ph: Email: Cell Ph: PATIENT INFORMATION # Date: 03/01/2023 Post Sx: Sx Date: Type: WC REFERRING DOCTOR INFORMATION Name: MOJABE, MOHAMMAD ROCKNY **Body Pts:** Address: RANCHO CUCAMONGACA City, Zip: Phone: (909)466-8888 Dx: ATTORNEY INFORMATION Name: Address: City, Zip: Phone: **EMPLOYMENT INFORMATION:** Name: Address: Phone: City, Zip: PRIMARY INSURANCE INFORMATION SECONDARY INSURANCE INFORMATION Name: Name: Address: Address: Adj/Ph#: Adj/Ph#: Type: Type: Ins Name: Ins Name: Pol#/Clm#: Pol#/Clm#: RELEASE OF INFORMATION and ASSIGNMENT OF BENEFITS I hereby authorize WestStar Physical Therapy to release information requested by my insurance carrier concerning this illness upon request. I hereby authorize direct payment of my insurance benefits to WestStar Physical Therapy for services rendered.

| | 05/03/23 |
|----------------|-------------|
| SHAWNEE MURRAY | Date Signed |



JOB INFORMATION #

Document Date: 05/03/23

| JOB INFORMATION # Job Title: Job Description: ADDITIONAL JOB DETAILS During a typical 8-hour day, How many hours do you? Sit: Hours Squatting: Hours Stand: Hours Kneeling: Hours Hours Hours | PATIENT | # | | | | | |
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| ADDITIONAL JOB DETAILS During a typical 8-hour day, How many hours do you? Sit: | Name: | SHAWNEE MUR | RRAY | SSN: | xxx | <-XX9999 | |
| ADDITIONAL JOB DETAILS During a typical 8-hour day, How many hours do you? Sit: | JOB INFO | RMATION# | | | | | |
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| | | 4 1 1 | | | | | _ [] |
| Timed work for efficiency: | | | | | | | _{ |
| Simultaneous computer & telephone : | | | | | - | _ } } | |



INJURY INFORMATION

Document Date: 05/03/23

| PATIENT | # | | | | |
|---------------|------------------------------|------------------------|---------------|-------------|--------|
| Name: | SHAWNEE MURRAY | | SSN: | XXX-XX9999 | |
| INJURY I | NFORMATION # | | | | |
| Briefly desci | ribe your injury : | | | | |
| | | | | | Yes No |
| Did you go | to the Emergency Room | n at a Hospital? | | | |
| If not an E | mergency Room, Ad you | go to some other ty | pe of medical | I facility? | |
| Were x-ray | ys taken? | | | | |
| If an auto a | accident, was the vehicle | drivable after the acc | cident? | | |
| Do you ha | ve any previous injury to | the sense area? | | | |
| Are you st | ill being treated for this i | njury? | | | |
| | | | | | |
| If you are | still being treated for this | injury, by whom? | | | |
| Name: | | | | | |
| Address: | | | | | |
| City, Zip: | | | | | |
| Phone | | | | | |



PAIN INFORMATION

Document Date: 05/03/23

PATIENT

Name: SHAWNEE MURRAY SSN: XXX-XX9999

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: 05/03/23

| PATIENT # | | | | | |
|-----------|----------------|-------|------------|--|--|
| Name: | | SSN: | | | |
| ivanie. | SHAWNEE MURRAY | 55IN: | XXX-XX9999 | | |

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: 05/03/23

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| PA | IIH.I | V | # |

| Name: | SHAWNEE MURRAY | SSN: | XXX-XX9999 |
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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: 05/03/23

| PATIENT # | | | | | | |
|-------------|--|-----------------|--|--------|--|--|
| Name: | SHAWNEE MURRAY | SSN: | XXX-XX9999 | | | |
| PRIVACY | INFORMATION Page (2 of 3) | | | | | |
| Appointme | ent Reminders: Your health information w | ill be used by | our staff to send you appointment remin | nders. | | |
| interesting | on About Treatments: Your health informat on the treatment and management of your n describing only West Star related inform | medical cond | lition. From our database, we may also s | | | |
| | Please do not use my health infor | rmation for the | e 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: 05/03/23

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| Name: | SHAWNEE MURRAY | SSN: | XXX-XX9999 |
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PRIVACY INFORMATIONPage (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



Document Date: 05/03/23

| PATIENT | # | | |
|------------|---|---------------|--|
| Name: | SHAWNEE MURRAY | SSN: | XXX-XX9999 |
| PRIVACY | ACKNOWLEDGMENT INFORMATION | | |
| acknowled | Acknowledgement of Received, read and fully understand the Notice of 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 | presentative is required if the patient is a mine | or or patient | is an adult who is unable to sign this form. |
| | Relationship to Patient :_ | | |