

Patient Information and Treatment Authorization

Document Date: 02/09/23

PATIENT INFORMATION # WESTSTAR ANAHEIM SILVIA MORALES XXX-XX-9999 Name: SSN: Address: 10201 SONNET STREET Sex: F STANTON,CA,90680 11/03/1989 City, Zip: DOB: (714)678-7403 33 Home Ph: Age: Work Ph: **Email:** Cell Ph: PATIENT INFORMATION # Date: 09/23/2022 Post Sx: Sx Date: Type: PΙ REFERRING DOCTOR INFORMATION Name: MILLER, LAWRENCE ROSS **Body Pts:** Address: 1450 E 17TH ST STE 100 SANTA ANA, CA, 92705 City, Zip: Phone: (714)565-1000 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 West-Star Physical Therapy to release information requested by my insurance carrier concerning this illness 02/09/23 SILVIA MORALES Date Signed



JOB INFORMATION #

Document Date: 02/09/23

JOB INFORMATION # Job Title: Job Description: At work, on average, how much time Squatting: Hours do you spend Stand: Hours Stand: Hours Hours Kneeling: Hours At work, on average, how much time Squatting: Hours do you spend Squatting: Hours Kneeling: Hours At work, on average, how much time Squatting: Hours do you work standing: Hours Reaching Up: Hours At work, on average, how much time Squatting: Hours Kneeling: Hours Reaching Up: Hours Twisting: Hours Crawling: Hours Using a Computer: Using the Telephone: Hours Hours Publing: Hours At work, my job requires that I lift Constantly Often Sometimes Never At work, my job includes Constantly Often Sometimes Never Repetitive Hoad Movement: Power Gripping: Hours Never Repetitive Foot Movement: Power Gripping: Hours Never Repetitive Foot Movement: Power Gripping: Hours Never	PATIENT	#						
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INJURY INFORMATION

Document Date: 02/09/23

PATIENT :	#						
Name:	SILVIA MORALES		SSN:	XXX-XX-9999			
INJURY IN	NFORMATION #						
Briefly descri	ibe your injury :						
					Yes	No	
Did you go	to the Emergency Ro	oom at a Hospital?					
If not an Er	mergency Room, Ad	you go to some other ty	pe of medical fac	cility?			
Were x-ray	s taken?						
If an auto a	ccident, was the vehi	cle drivable after the acc	cident?				
Do you hav	ve any previous injury	to the sense area?					
Are you sti	ll being treated for th	is injury?					
If you are s	till being treated for t	this injury, by whom?					
Name:							
Address:							
City, Zip:	City, Zip:						
Phone							



PAIN INFORMATION

Document Date: 02/09/23

PATIENT

Name: SILVIA MORALES SSN: XXX-XX-9999

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: 02/09/23

PATIENT #				
Name:	SILVIA MORALES	SSN:	XXX-XX-9999	

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 THERAPIST 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: 02/09/23

PATIENT #				
Name:	SILVIA MORALES	SSN:	XXX-XX-9999	

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: 02/09/23

PATIENT #					
Name:	SILVIA MORALES	SSN:	XXX-XX-9999		
PRIVACY	Y INFORMATION Page (2 of 3)				
Appointme	ent Reminders: Your health informa	ntion will be used by ou	ur staff to send you appointment reminders.		
interesting		of your medical condit	d to send you information that you may find ion. From our database, we may also send you be of interest to you**		
	Please do not use my heal	th 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: 02/09/23

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Name:	SILVIA MORALES	SSN:	XXX-XX-9999

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

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: 02/09/23

PATIENT	#		
Name:	SILVIA MORALES	SSN:	XXX-XX-9999
PRIVACY	ACKNOWLEDGMENT INFORMATION	N	
acknowled	Acknowledgement of Received, read and fully understand the Notice lge and understand that West Stat Physical outlined in the notice.	e of Privacy Pr	· ·
	Patien SIGNATURI Da	E:	
Patient Re	presentative is required if the patient is a m	ninor or patient	is an adult who is unable to sign this form.
	Name of Patient Representativ Relationship to Patient SIGNATURI Da	t : E:	