

Patient Information and Treatment Authorization

PATIENTI	NFORMATION #		WESTSTAR MONTCLAII
Name:	ROGELIO ZAVALA LOPEZ	SSN:	XXX-XX0130
Address:	1066 W VESTA STREET	Sex:	M
City, Zip:	ONTARIOCA91762	DOB:	10/07/1960
Home Ph:	(909)545-5197	Age:	62
Work Ph:		Email:	
Cell Ph:	(909)919-0878		
PATIENT II	NFORMATION#		
Date:	05/19/2019	Post Sx:	
Type:	WC	Sx Date:	
REFERRIN	G DOCTOR INFORMATION		
Name:	SALOMON, MICHAEL	Body Pts :	
Address:	155 W HOSPITALITY LANE STE 220		
City, Zip:	SAN BERNARINOCA92408		
Phone:	(323)435-4523	Dx:	
ATTORNEY	Y INFORMATION		
Name :		Address:	
City, Zip:		Phone:	
EMPLOYM	ENT INFORMATION:		
Name :	BARTH FARMS	Address:	
City, Zip:		Phone:	
PRIMARY 1	INSURANCE INFORMATION	SECONDAR	Y INSURANCE INFORMATION
Name :	SCIF	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 aut concerning t	horize WestStar Physical Therapy to rele his illness upon request. I hereby authorize erapy for services rendered.	ase information r	
		06/02/23	
ROGELIO	ZAVALA LOPEZ	Date Sig	ned



JOB INFORMATION #

PATIENT	#					
Name:	ROGELIO Z	ZAVALA LOPEZ	SSN:	xxx	-XX0130	
JOB INFO	RMATION#					
Job Title:						
Job Descript	ion:					
ADDITION	NAL JOB DE	TAILS				
During a typ	sical 9 hour day	How many hours do you?	At worl	k. on average. h	ow much time do you	spend?
Sit:	near 8-nour day,	Hours	Squattin	_		Hours
Stand:		Hours		g/bending:		Hours
Walk:		Hours	Kneelin			Hours
Drive:		Hours	Reachin			Hours
			Reachin			Hours
	n average, hov	w many hours do you wo	rK	Twisting:		Hours
per			Crawlin			Hours
Day/Shift:		Hours	Stair Climbing:			Hours
Week:		Hours		Climbing:		Hours
				Computer:		Hours
				ne Telephone :		Hours
						\dashv
			Pushing			Hours
			Pulling			Hours
			Lifting (Overhead:		Hours
At work, m	ny job requires	that I lift	Constantly	Often	Sometimes	Never
10 lbs or less						
11 lbs to 25 lb						
26 lbs to 50 lb						
51 lbs to 75 lb] []
76 lbs to 100 over 100 lbs :		_			_	
0 (01 100 108 .	•					
At work, n	ny job includes	S	Constantly	Often	Sometimes	Never
Repetitive Ha	and Movement:					
	ot Movement:					
Power Grippi						
Precision Har	ndling:					
Balancing:	ytan mas /- 1					
	iter mouse/touch j for efficiency:	pau:			_	{
	computer & telep	phone :			_{ }	{



INJURY INFORMATION

PATIENT	#			
Name:	ROGELIO ZAVALA LOPEZ	SSN:	XXX-XX0130	
INJURY I	NFORMATION #			
Briefly desci	ribe your injury :			
				Yes No
Did you go	to the Emergency Room at a Hos	pital?		
If not an E	mergency Room, Ad you go to son	me other type of medica	al facility?	
Were x-ray	ys taken?			
If an auto a	accident, was the vehicle drivable	after the accident?		
Do you ha	ve any previous injury to the sense	e area?		
Are you st	ill being treated for this injury?			
If you are	still being treated for this injury, by	y whom?		
Name:				
Address:				
City, Zip:				
Phone				



PAIN INFORMATION

Document Date: 06/02/23

PATIENT

Name: ROGELIO ZAVALA LOPEZ SSN: XXX-XX0130

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







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PATIENT #				
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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	



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PATIENT

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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.



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PATIENT	`#			
Name:	ROGELIO ZAVALA LOPEZ	SSN:	XXX-XX0130	
PRIVACY	Y INFORMATION Page (2 of 3)			
Appointme	ent Reminders: Your health information	will be used by o	our staff to send you appointment reminders.	
interesting		our medical condi	ed to send you information that you may find ition. From our database, we may also send y be of interest to you**	
	Please do not use my health in	formation 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.



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Name:	ROGELIO ZAVALA LOPEZ	SSN:	XXX-XX0130

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



PATIENT	#		
Name:	ROGELIO ZAVALA LOPEZ	SSN:	XXX-XX0130
PRIVACY	ACKNOWLEDGMENT INFORMATION	ſ	
acknowled	Acknowledgement of Received, read and fully understand the Notice lige and understand that West Stat Physical toutlined in the notice.	of Privacy Pr	•
	Patient SIGNATURE Date	: 	
Patient Re	Name of Patient Representative Relationship to Patient	:	is an adult who is unable to sign this form.