Patient Information and Treatment Authorization

Document Date : 02/01/23

PATIENT INFORMATION

WESTSTAR RIVERSIDE

Name :	ANGEL OCHOA	SSN :	XXX-XX-8318
Address :	850 LA QUINTA WAY	Sex :	M
City, Zip:	NORCO,CA,92860	DOB :	09/20/1988
Home Ph :	(310)467-9822	Age:	34
Work Ph :		Email:	
Cell Ph:			

PATIENT INFORMATION

Date:	08/30/2022	Post Sx :	
Type :	WC	Sx Date:	

REFERRING DOCTOR INFORMATION

Name :	DORSEY, JOHN	Body Pts :	
Address :	25431 CABOT ROAD STE 110		
City, Zip:	LAGUNA HILLS,CA,92653		
Phone :	(949)716-1900	Dx:	

ATTORNEY INFORMATION

Name :		Address :	
City, Zip:		Phone :	

EMPLOYMENT INFORMATION :

Name :		Address :	
City, Zip:		Phone :	

PRIMARY INSURANCE INFORMATION

Name :	
Address :	
Adj/Ph#:	
Type :	
Ins Name :	
Pol#/Clm#:	

SECONDARY INSURANCE INFORMATION

Name :	
Address :	
Adj/Ph#:	
Type :	
Ins Name :	
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

02/01/23

ANGEL OCHOA — Date Signed

JOB INFORMATION #

Document Date : 02/01/23

PATIENT #

Name : ANGEL OCHOA **SSN:** XXX-XX-8318

JOB INFORMATION #

Job Title:

Job Description:

ADDITIONAL JOB DETAILS

During: Hoa typical 8 hour day, How malthootusrs do you...

Sit : Hours

Stand : Hours

Walk : Hours

Drive : Hours

At work, on average, how many hours do you work per...

Day/Shift : Hours

Week : Hours

At work, on average, how much time Squatting: Hours
do you spend...

Squatting : Hours

Stooping/bending : Hours

Kneeling : Hours

Reaching Up : Hours

Reaching Out : Hours

Twisting : Hours

Crawling : Hours

Stair Climbing : Hours

Ladder Climbing : Hours

Using a Computer :		Hours
Using the Telephone :		Hours
Pushing :		Hours
Pulling :		Hours
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 Ibs :				
over 100 Ibs :				

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 :				
Simultaneous computer & telephone :				

INJURY INFORMATION

Document Date : 02/01/23

PATIENT #

Name : ANGEL OCHOA **SSN:** XXX-XX-8318

INJURY INFORMATION #

Briefly describe your injury :

	Yes	No
Did you go to the Emergency Room at a Hospital?		
If not an Emergency Room, Ad you go to some other type of medical facility?		
Were x-rays taken?		
If an auto accident, was the vehicle drivable after the accident?		
Do you have any previous injury to the sense area?		
Are you still being treated for this injury?		

If you are still being treated for this injury, by whom?

Name :

Address :

City, Zip:

Phone

PAIN INFORMATION

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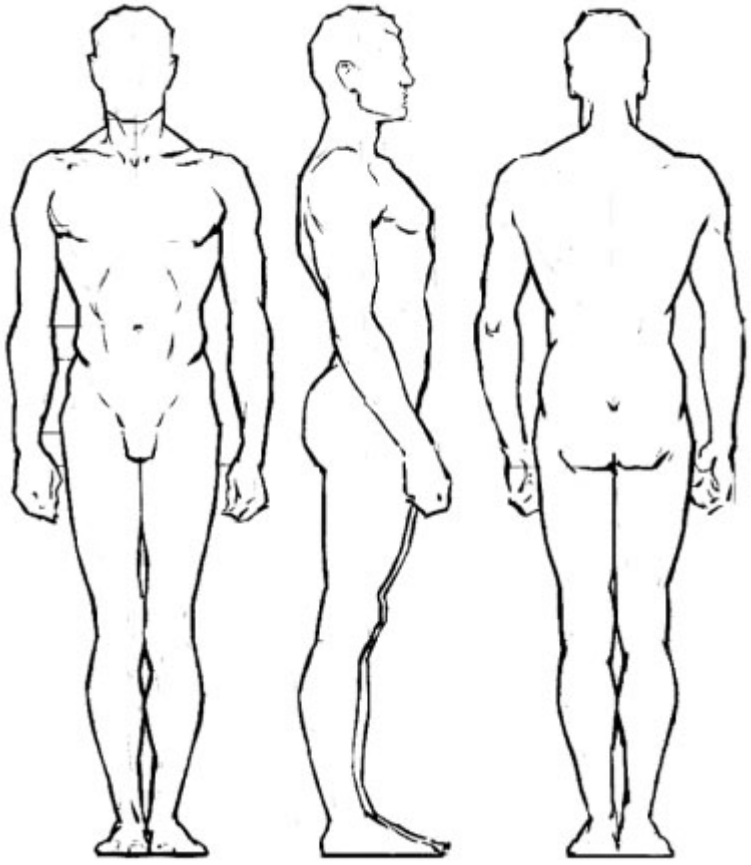
Name : ANGEL OCHOA **SSN:** XXX-XX-8318

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



Waiver

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Name : ANGEL OCHOA **SSN:** XXX-XX-8318

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 _____

Notice of Privacy Practices

Document Date : 02/01/23

PATIENT #

Name : ANGEL OCHOA **SSN:** XXX-XX-8318

PRIVACY INFORMATION Page (1 of 3)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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.

Notice of Privacy Practices

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PATIENT #

Name : ANGEL OCHOA **SSN:** XXX-XX-8318

PRIVACY INFORMATION Page (2 of 3)

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. From our database, we may also send you information describing only West Star related information that may be of interest to you**

☐ Please do not use my health 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.

PATIENT #

Name : ANGEL OCHOA **SSN:** XXX-XX-8318

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

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

Privacy Practices Acknowledgement

Document Date : 02/01/23

PATIENT #

Name : ANGEL OCHOA **SSN:** XXX-XX-8318

PRIVACY ACKNOWLEDGMENT INFORMATION

Acknowledgement of Receipt of Notice of Privacy Practices

I, have received, read and fully understand the Notice of Privacy Practices for West Star Physical therapy and acknowledge and understand that West Stat Physical therapy reserves the right to modify or amend the privacy practices outlined in the notice.

Patient :
SIGNATURE: _____
Date _____

Patient Representative is required if the patient is a minor or patient is an adult who is unable to sign this form.

Name of Patient Representative: _____
Relationship to Patient : _____
SIGNATURE: _____
Date _____