

Patient Information and Treatment Authorization

PHYSICAL THERAPY NETWORK	Document Date: 06/21/23
PATIENT INFORMATION #	WESTSTAR SAN BERNARDING

Name:	GUSTAVO DE LA ROCHA	SSN:	XXX-XX9999
Address:	14641 ADOBE PALCE	Sex:	M
City, Zip:	VICTORVILLECA92394	DOB:	01/21/1988
Home Ph:	(562)286-3342	Age:	35
Work Ph:		Email:	
Cell Ph:			
PATIENT IN	FORMATION #		
Date:	10/15/2020	Post Sx:	
Type:	PI	Sx Date:	
REFERRING	DOCTOR INFORMATION		
Name:	ELDRINGHOFF, DAVID	Body Pts:	
Address:	420 W ROWLAND ST		
City, Zip:	COVINACA91723		
Phone:	(626)331-6411	Dx:	
ATTORNEY	INFORMATION		
Name:		Address:	
City, Zip:		Phone:	
EMPLOYME	ENT INFORMATION:		
Name:		Address:	
City, Zip:		Phone:	
PRIMARY II	NSURANCE INFORMATION	SECONDARY	INSURANCE INFORMATION
Name:		Name:	
Address:		Address:	
Adj/Ph#:		Adj/Ph#:	
Type:		Type:	
Ins Name :		Ins Name:	
Pol#/Clm#:		Pol#/Clm#:	
RELEASE O	F INFORMATION and ASSIGNMENT O	F BENEFITS	
I hereby auth concerning th	orize WestStar Physical Therapy to release is illness upon request. I hereby authorize apy for services rendered.	e information req	
		06/21/23	
GUSTAVO	DE LA ROCHA	Date Signe	ed



JOB INFORMATION #

Document Date: 06/21/23

PATIENT	#					
Name:	GUSTAVO DE L	A ROCHA	SSN:	XX	X-XX9999	
JOB INFO	RMATION#					
Job Title:						
Job Descript	ion:					
ADDITION	NAL JOB DETAIL	S				
	THE SOD DETTILE					
During a typ	ical 8-hour day, How	many hours do you?	At work	, on average,	how much time do y	ou spend?
Sit:		Hours	Squatting	g:		Hours
Stand:		Hours	Stooping	/bending:		Hours
Walk:		Hours	Kneeling	; :		Hours
Drive :		Hours	Reaching	g Up :		Hours
	1		Reaching	g Out :		Hours
per	n average, now ma	ny hours do you wo	rk Twisting	;:		Hours
		7 ,,	Crawling			Hours
Day/Shift:		Hours	Stair Cli			Hours
Week:		Hours		Climbing:		Hours
				Computer :		Hours
				e Telephone :		Hours
			Pushing			Hours
			Pulling:			Hours
			_			
			Litting C	Overhead:		Hours
	ny job requires that	I lift	Constantly	Often	Sometimes	Never
10 lbs or less						
11 lbs to 25 ll						
26 lbs to 50 ll						
51 lbs to 75 ll						
76 lbs to 100 over 100 lbs :		_				
over 100 lbs :						
At work, n	ny job includes		Constantly	Often	Sometimes	Never
Repetitive Ha	and Movement:					
Repetitive Fo	ot Movement :					
Power Grippi	ng:					
Precision Har	ndling:					
Balancing:						
	iter mouse/touch pad:					
	for efficiency:					
Simultaneous	computer & telephone	:				



INJURY INFORMATION

Document Date: 06/21/23

PATIENT	#				
Name:	GUSTAVO DE LA ROCH	IA	SSN:	XXX-XX9999	
INJURY I	NFORMATION#				
Briefly desc	ribe your injury :				
					Yes No
Did you go	to the Emergency Room	at a Hospital?			
If not an E	mergency Room, Ad you	go to some other ty	pe of medica	al facility?	
Were x-ra	ys taken?				
If an auto	accident, was the vehicle of	rivable after the ac	cident?		
Do you ha	ve any previous injury to t	he sense area?			
Are you still being treated for this injury?					
If you are	still being treated for this i	njury, by whom?			
Name:					
Address:					
City, Zip:					
Phone					



PAIN INFORMATION

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PATIENT

Name: GUSTAVO DE LA ROCHA 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







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PATIENT #			
Name:	GUSTAVO DE LA ROCHA	SSN:	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	



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Name:	GUSTAVO DE LA ROCHA	SSN:	XXX-XX9999

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:	GUSTAVO DE LA ROCHA	SSN:	XXX-XX9999		
PRIVACY	(INFORMATION Page (2 of 3)				
Appointm	ent Reminders: Your health information	on will be used by or	ur staff to send you appointment reminders.		
interesting		your medical condit	d to send you information that you may find ion. From our database, we may also send yo be of interest to you**	u	
	Please do not use my health i	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.



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PATIENT

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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



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PATIENT	#		
Name:	GUSTAVO DE LA ROCHA	SSN:	XXX-XX9999
PRIVACY	ACKNOWLEDGMENT INFORMATION	N	
acknowled	Acknowledgement of Received, read and fully understand the Notice and understand that West Stat Physical putlined in the notice.	of Privacy Pr	· ·
	Patient SIGNATURE Dat	E:	
Patient Re	presentative is required if the patient is a m	inor or patient	t is an adult who is unable to sign this form.
	Name of Patient Representative Relationship to Patient SIGNATURE Date	: : E:	