

SARAH STITT MCGRADE

Patient Information and Treatment Authorization

Document Date : 08/07/23

PATIENT IN	FORMATION #		WESTSTAR HOLLYWOOD
Name:	SARAH STITT MCGRADE	SSN:	XXX-XX9999
Address:	6100 BARROWS DRIVE	Sex:	F
City, Zip:	LOS ANGELESCA90048	DOB:	05/28/1963
Home Ph:	(323)839-4448	Age:	60
Work Ph:		Email:	
Cell Ph:			
PATIENT IN	FORMATION #		
Date:	07/12/2023	Post Sx:	
Type:	PI	Sx Date:	
REFERRING	DOCTOR INFORMATION		
Name:	MILLER, LAWRENCE ROSS	Body Pts:	
Address:	8641 WILSHIRE BLVD STE 200		
City, Zip:	BEVERLY HILLSCA90211		
Phone:	(310)657-7246	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	
	orize WestStar Physical Therapy to release		
	is illness upon request. I hereby authorize apy for services rendered.	direct payment o	f my insurance benefits to WestStar
		08/07/23	
		UO/U1/43	

Date Signed



JOB INFORMATION #

Document Date: 08/07/23

JOB INFORMATION # Job Title: Job Description: ADDITIONAL JOB DETAILS During a typical 8-hour day, How many hours do you? At work, on average, how much time do you spend?	PATIENT	#					
ADDITIONAL JOB DETAILS During a typical 8-hour day, How many hours do you? Si:	Name:	SARAH STITT N	MCGRADE	SSN:	XXX	(-XX9999	
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Timed work for efficiency:							
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INJURY INFORMATION

Document Date: 08/07/23

PATIENT	#				
Name:	SARAH STITT MCG	RADE	SSN:	XXX-XX9999	
INJURY I	NFORMATION #				
Briefly desc	ribe your injury :				
					Yes No
Did you go	o to the Emergency Ro	om at a Hospital?			
If not an E	Emergency Room, Ad y	ou go to some other typ	pe of medical	facility?	
Were x-ra	ys taken?				
If an auto	accident, was the vehic	ele drivable after the acc	cident?		
Do you ha	ve any previous injury	to the sense area?			
Are you st	ill being treated for thi	s injury?			
If you are	still being treated for the	nis injury, by whom?			
Name:					
Address:					
City, Zip:					
Phone					



PAIN INFORMATION

Document Date: 08/07/23

PATIENT

Name: SARAH STITT MCGRADE 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: 08/07/23

PATIENT #						
Name:	SARAH STITT MCGRADE	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	



Notice of Privacy Practices

Document Date: 08/07/23

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PA	 IIH.I	V	#

Name:	SARAH STITT MCGRADE	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.



PATIENT #

Notice of Privacy Practices

Document Date: 08/07/23

	"		***************************************							
Name:	SARAH STITT MCGRADE	SSN:	XXX-XX9999							
PRIVACY	INFORMATION Page (2 of 3)									
Appointme	ent Reminders: Your health information	will be used by or	ar staff to send you appointment re	minders.						
interesting	n About Treatments: Your health inform on the treatment and management of you n describing only West Star related info	our medical condit	ion. From our database, we may al							

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.



Notice of Privacy Practices

Document Date: 08/07/23

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Name:	SARAH STITT MCGRADE	SSN:	XXX-XX9999

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



Notice of Privacy Practices

Document Date: 08/07/23

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SARAH STITT MCGRADE	SSN:	XXX-XX9999
ACKNOWLEDGMENT INFORMATION	Ī	
eived, read and fully understand the Notice	of Privacy Pr	ractices for West Star Physical therapy and
SIGNATURE		
Name of Patient Representative Relationship to Patient SIGNATURE	:: ::	<u> </u>
	ACKNOWLEDGMENT INFORMATION Acknowledgement of Received, read and fully understand the Notice ge and understand that West Stat Physical futlined in the notice. Patient SIGNATURE Date or seen tative is required if the patient is a minus of Patient Representative Relationship to Patient SIGNATURE	SARAH STITT MCGRADE ACKNOWLEDGMENT INFORMATION Acknowledgement of Receipt of Notice eived, read and fully understand the Notice of Privacy Prige and understand that West Stat Physical therapy reserve utlined in the notice. Patient: SIGNATURE: Date Date Dresentative is required if the patient is a minor or patient Name of Patient Representative: Relationship to Patient: