



## Patient Information and Treatment Authorization

Document Date : 06/15/23

### PATIENT INFORMATION #

Name :	<input type="text"/>	SSN :	<input type="text"/>
Address :	<input type="text"/>	Sex :	<input type="text"/>
City, Zip:	<input type="text"/>	DOB :	<input type="text"/>
Home Ph :	<input type="text"/>	Age:	<input type="text"/>
Work Ph :	<input type="text"/>	Email:	<input type="text"/>
Cell Ph:	<input type="text"/>		<input type="text"/>

### PATIENT INFORMATION #

Date:	<input type="text"/>	Post Sx :	<input type="text"/>
Type :	<input type="text"/>	Sx Date:	<input type="text"/>

### REFERRING DOCTOR INFORMATION

Name :	<input type="text"/>	Body Pts :	<input type="text"/>
Address :	<input type="text"/>		
City, Zip:	<input type="text"/>		
Phone :	<input type="text"/>	Dx:	<input type="text"/>

### ATTORNEY INFORMATION

Name :	<input type="text"/>	Address :	<input type="text"/>
City, Zip:	<input type="text"/>	Phone :	<input type="text"/>

### EMPLOYMENT INFORMATION :

Name :	<input type="text"/>	Address :	<input type="text"/>
City, Zip:	<input type="text"/>	Phone :	<input type="text"/>

### PRIMARY INSURANCE INFORMATION

### SECONDARY INSURANCE INFORMATION

Name :	<input type="text"/>	Name :	<input type="text"/>
Address :	<input type="text"/>	Address :	<input type="text"/>
Adj/Ph#:	<input type="text"/>	Adj/Ph#:	<input type="text"/>
Type :	<input type="text"/>	Type :	<input type="text"/>
Ins Name :	<input type="text"/>	Ins Name :	<input type="text"/>
Pol#/Clm#:	<input type="text"/>	Pol#/Clm#:	<input type="text"/>

### RELEASE OF INFORMATION and ASSIGNMENT OF BENEFITS

I hereby authorize WestStar Physical Therapy to release information requested by my insurance carrier concerning this illness upon request. I hereby authorize direct payment of my insurance benefits to WestStar Physical Therapy for services rendered.

06/15/23

Date Signed





## INJURY INFORMATION

Document Date : 06/15/23

### PATIENT #

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Name :

SSN:

### INJURY INFORMATION #

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Briefly describe your injury :

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

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

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Name :

Address :

City, Zip:

Phone

PATIENT # \_\_\_\_\_

Name :

SSN:

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  
O = Other





PATIENT #

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Name :

SSN:

WAIVER INFORMATION

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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 \_\_\_\_\_



## Notice of Privacy Practices

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PATIENT #

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Name :

SSN:

PRIVACY INFORMATION Page (1 of 3)

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**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.



## Notice of Privacy Practices

Document Date : 06/15/23

PATIENT #

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Name :

SSN:

PRIVACY INFORMATION Page (2 of 3)

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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\*\*

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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.



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Name :

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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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SSN:

### 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 \_\_\_\_\_