

PATIENT INFORMATION

LAST NAME:		FIRST NAME:		MI:	DAYTIME PHONE:	
DATE OF BIRTH:	AGE:	SEX: MALE FEMALE		EMAIL ADDRESS:		
MAILING ADDRESS:			CITY:	STATE:	ZIP:	
PHYSICAL ADDRESS (IF DIFFERENT THAN ABOVE):			CITY:	STATE:	ZIP:	
PATIENT'S EMPLOYER:			OCCUPATION:			
EMPLOYER ADDRESS:			CITY:	STATE:	ZIP:	
WORK PHONE:						
TYPE OF INJURY: WORK AUTO OTHER:				DATE OF INJURY:		
REASON FOR VISIT:		REFERRING PHYSICIAN:		HOW DID YOU HEAR ABOUT US?		
EMERGENCY CONTACT:			RELATIONSHIP:		PHONE NUMBER:	

SPOUSE/PARENT/GUARANTOR INFORMATION

LAST NAME:		FIRST NAME:		MI:	HOME PHONE:	
DATE OF BIRTH:	AGE:	SEX: MALE FEMALE		RELATIONSHIP:		
ADDRESS:			CITY:	STATE:	ZIP:	
EMPLOYER:			OCCUPATION:		WORK PHONE:	
EMPLOYER ADDRESS:			CITY:	STATE:	ZIP:	

INSURANCE INFORMATION

1. PRIMARY INSURANCE:				PHONE NUMBER:	
POLICY / CLAIM #:			GROUP #:		EFFECTIVE DATE:
DEDUCTIBLE:	PORTION MET:	INSURANCE PAYS:	PATIENT RESPONSIBILITY:		
LIMITATIONS:					
2. SECONDARY INSURANCE:				PHONE NUMBER:	
POLICY / CLAIM#:			GROUP #:		EFFECTIVE DATE:
DEDUCTIBLE:	PORTION MET:	INSURANCE PAYS:	PATIENT RESPONSIBILTY:		
LIMITATIONS:					

I have read the above estimation of benefits from my insurance company and agree to verify this information by contacting my insurance company. I do not hold PacificPro Physical Therapy & Sports Medicine responsible for any incorrect or omitted information or for any changes in my future coverage. I also agree that I am responsible for the contract between myself and my insurance company.

SIGNATURE: _____

DATE: _____

RELEASE OF INFORMATION

All information provided herein is true and correct.

I hereby consent to treatment.

I give permission to PacificPro Physical Therapy & Sports Medicine to release information, verbal and written, contained in my medical record, and other related

information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare provider, assignees and/or beneficiaries and all other

related persons as it relates to my treatment.

I authorize PacificPro Physical Therapy & Sports Medicine to obtain medical records and/or professional information from my physician or other medical professional

as it relates to my treatment.

Information without patient identifiers may be used for quality assurance purposes.

I have read and understand the above release.

PATIENT/GUARDIAN SIGNATURE:

DATE:

ASSIGNMENT OF BENEFITS

I authorize payment directly to PacificPro Physical Therapy & Sports Medicine for services.

This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

PATIENT/GUARDIAN SIGNATURE:

DATE:

PAYMENT GUARANTEE

I agree to pay PacificPro Physical Therapy & Sports Medicine for the services provided me or the party named above. If any law, such as workers' compensation or insurance contract, prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The benefit verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of PacificPro Physical Therapy & Sports Medicine.

PATIENT/GUARDIAN SIGNATURE:

DATE:

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for PacificPro Physical Therapy & Sports Medicine.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

PATIENT/GUARDIAN SIGNATURE:

DATE:

HISTORY AND PHYSICAL CONDITION INFORMATION

Name: _____ Age: _____

Referring Physician: _____ Today's Date: _____

Problems to be treated: _____

Have you had treatment for this problem before? YES NO

If YES, state where: _____ When: _____

Treatment given: _____

Have you had surgery associated with this problem? YES NO

If YES, please list date and type of surgery: _____

Are you currently taking any medications? Yes NO

If YES, please list all medications: _____

Do you now have/or have you had any of the following:

High Blood Pressure	YES	NO	Sensitive to Heat/Ice	YES	NO
Heart Disease	YES	NO	Allergies	YES	NO
Heart Attack	YES	NO	Hernia	YES	NO
Pacemaker	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Metal Implants	YES	NO
Headaches	YES	NO	Dizzy Spells	YES	NO
Kidney Problems	YES	NO	Balance Problems	YES	NO
Nervous Disorder	YES	NO	Vision Problems	YES	NO
Hearing Problems	YES	NO			

If yes on any of the above, please explain and give approximate dates: _____

Have you ever had therapy before: YES NO

Are you pregnant: YES NO

List any major illness or surgery that has occurred in the past year: _____

The above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

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 evaluations 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 of dates of service, the 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 and management of PacificPro Physical Therapy & Sports Medicine. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required by law to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

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

YOUR HEALTH INFORMATION RIGHTS

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your health information
- the right to amend and/or submit corrections to your health information
- the right to receive an accounting of how and to whom your health information has been disclosed
- the right to receive a printed copy of this notice

OUR HEALTH INFORMATION 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 also are required to abide by the privacy policies and practices that are outlined in this notice.

OUR RIGHTS TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or 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. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, 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 the company's privacy officer.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the company by sending a letter outlining your concerns to:

Privacy Officer
PacificPro Physical Therapy & Sports Medicine
1 Peter's Canyon Road, Suite 120
Irvine, CA 92606

You may also file a written complaint with the Office of Civil Rights.