PACIFICPRO
PHYSICAL THERAPY & SPORTS MEDICINE

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:		
WORK PHONE:			
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:	

INSURANCE INFORMATION

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

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:** _____

PACIFICPRO
PHYSICAL THERAPY & SPORTS MEDICINE

MEDICAL HISTORY QUESTIONNAIRE

Have you been a patient here before? Yes or No (Circle one)
How did you hear about PacificPro?

1. Doctor: _____
2. Family Member / Friend: _____
3. Insurance: _____
4. Internet Search: _____
5. Other: _____

Name of Doctor who referred you: _____

Date of your follow up visit with this Doctor: _____
(Note: This date is needed so that we can send a progress report before this follow up appointment)

Is this a WORK related injury? Yes or No

Is this an AUTO related injury? Yes or No
If yes, please provide us with the amount of medical payment your auto insurance will cover.

Have you had treatment for this problem before? Yes or No
If yes, ***Where:***_____ ***When:***_____
Treatment given:_____

Have you had surgery associated with this problem? Yes or No
*If yes, please list date and type of surgery:*_____
_____

Are you currently taking any medications? Yes or No
*If yes, please list all medications:*_____
_____

Are you pregnant? Yes or No

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	Cancer	YES	NO

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

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

PACIFICPRO
PHYSICAL THERAPY & SPORTS MEDICINE

DESCRIPTION OF SYMPTOMS

Date of Injury / Onset of Symptoms: _____

Are your symptoms: ☐Getting Better ☐Not Changing ☐Getting Worse

Describe how your injury occurred or when/how your symptoms began: _____

_____

_____

Describe your current complaints / symptoms: _____

_____

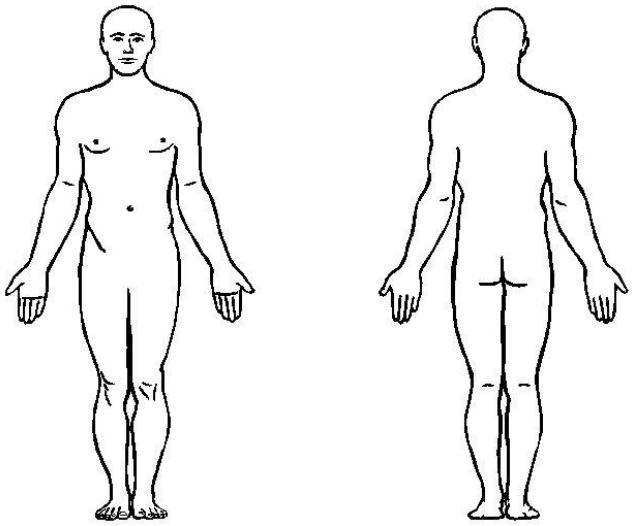
What activities in your daily life are affected the most by your current complaint, including recreational/social activities, functional activities, household duties, work, etc? _____

_____

_____

_____

PLEASE INDICATE ON THE DIAGRAM WHERE YOU EXPERIENCE YOUR SYMPTOMS



During the past 4 weeks, the most severe intensity of symptoms were:

0 1 2 3 4 5 6 7 8 9 10

Type of Pain:

shooting burning aching sharp dull tingling other _____

My symptoms are increased by: _____

_____

My symptoms are decreased by: _____

_____

The frequency of my symptoms are:

☐Constant (76-100% of day) ☐Frequent (51-75% of day) ☐Occasional (26-50% of day) ☐Intermittent (0-25% of day)

What are your goals with physical therapy? _____

_____

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

Signature:_____ Date:_____

PACIFICPRO
PHYSICAL THERAPY & SPORTS MEDICINE

RELEASE OF INFORMATION

All information provided herein is true and correct.
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:**

FINANCIAL RESPONSIBILITY

I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement.
I understand that if my insurance benefits and/or eligibility do not cover or approve payment for services provided by PacificPro, then I am financially responsible and agree to pay for all charges related to the services provided. This includes, but not limited to, services deemed 'non-covered' or 'not medically necessary' by my insurance.
Although I have requested PacificPro to bill my insurance company on my behalf, I clearly understand that I am responsible directly to PacificPro for my account regardless of the status of my insurance claim.
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 insurance information 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:**

CONSENT TO TREATMENT

I hereby consent to the therapeutic procedures outlined below, to be performed by PacificPro Physical Therapy & Sports Medicine and their associates.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as: heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation, and bladder training.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

I certify that I have read, and understand, the above consent statements.

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:**

PACIFICPRO
PHYSICAL THERAPY & SPORTS MEDICINE

COMMITMENT TO APPOINTMENTS POLICY

We strive to provide our patients with excellence of service and the utmost professionalism. Our commitment to your health and recovery is something every one in our company takes very seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive, and to the actions we ask you to perform.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

- **It is expected that you keep all your scheduled appointments** as we feel it can make the difference in the success of your treatment. We feel privileged to have you as our patient and are responsible to you and those referring parties for your treatment and care.
- **24 hours notice is required for an appointment to be rescheduled**. In such a case, please call our office and arrange for a make-up appointment. This appointment needs to be in the same week of the original appointment, preferably the very next day.

In an instance of a cancellation without 24 hours notice, or no-show to a scheduled appointment, we reserve the right to charge a $ 25 fee.

The only exception to the cancellation fee is in the case of an emergency. If there are repeated cancellations, we reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We greatly appreciate you as a patient and strive to accomplish your goals. Please help us be responsible for your care by being responsible enough to keep your appointments.

I have read and understand the commitment to appointments policy as set forth above.

_____

Signature **Date**

CREDIT CARD ON FILE AUTHORIZATION FORM

Please complete the form below if you would like to keep your credit card information on file with PacificPro. The information below will only be used for deductible, co-payments or co-insurance payments. The amount that will be charged will be discussed prior to processing. You may cancel this agreement at any time.

Cardholder Name _____

Cards Accepted – Visa, MasterCard, Discover, American Express

Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date __ __ / __ __ **Security Code *** __ __ __ __

(Security Code - 3 digit on the back of your card, except AMX – 4 digits on the front of card)

Credit Card Billing Address _____

City/State/Zip_____

Authorized Signature_____**Date**_____

PACIFICPRO
PHYSICAL THERAPY & SPORTS MEDICINE

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 OR 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 no 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 you 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.

PacificPro Physical Therapy & Sports Medicine
PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physical therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physical therapist, and the physical therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physical therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand of a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by party for such a party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of a person or entity which would otherwise be a proper additional party in a court action and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physical therapist within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below: Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOU RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: *PacificPro Physical Therapy & Sports Medicine*
Physical Therapist or Authorized Representative's Signature / Date

By: _____
Patient's or Patient Representative's Signature / Date

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.