

PATIENT INFORMATION

Name: _____ M / F Date of Birth: ____/____/____ Age: ____
Last First M.I.

Social Security No: ____ - ____ - ____ Driver's License Number: _____ Married: __ Single: __ Other: __

Address: _____
Street City State Zip

Email: _____

Home: (____) Cell: (____) Employed: Y / N F/T P/T Student
Preferred Contact Phone No.: Home Cell Work

Employer: _____ Occupation: _____ Work Phone: (____) _____

Work Address: _____

Spouse: _____ Social Security No: ____ - ____ - ____ DOB: ____/____/____

Emergency Contact: _____ Phone: (____) _____

Relationship to Patient: _____

Referring M.D.: _____ Phone: (____) _____

Previous Therapy & Location: _____ Date: _____

Date of Injury or Onset: ____/____/____ Body Part(s) Injured: _____

Did you sustain the injury at Work? Y N Are you covered under an employer or union policy? Y N

Are your injuries accident related? Y N Is your spouse or other family member employed? Y N

Auto accident other: _____ Do you have a secondary Insurance Policy? Y N

If this was an auto accident in what U.S. State did it take place?: _____

Attorney Name: _____ Attorney Phone number: _____

Name of Insured: _____ Relationship to Patient: _____

Date of Birth: ____/____/____ Employer: _____ Social Security No: ____ - ____ - ____

Primary Health Ins: _____ Secondary Health Ins: _____

ID No.: _____ Group No: _____ ID No.: _____ Group No: _____

As a courtesy, we will check your insurance benefits. You will receive a financial estimate for your review and signature. At that point, if there is a patient portion we will begin to collect it.

I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: ____/____/____

(Patient or Legal Guardian if Under 18)

Assignment of Benefits Form

Patient: _____

Employer: _____

Claim Group: _____

SS# / ID#: _____

I hereby authorize my Insurance Company to pay by check made out and mailed to:

Westlake Physical Therapy, Inc

or

If my current policy prohibits direct payment to Doctor, I hereby authorize you to make out the check to me and mail it as follows:

Patient Name: _____

C/O Westlake Physical Therapy, Inc
1220 La Venta Dr. Ste 102
Westlake Village, CA 91361

for the professional or medical expense benefits allowed by my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I understand that I am responsible for any balance of charges not covered by my insurance company which include the deductible & co-insurance.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Westlake Physical Therapy, Inc to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Patient or Legal Guardian (if under 18)

Date

Witness



ATTENTION PATIENTS!!!

- ALL COPAYS & CO-INS AMOUNTS MUST BE PAID PRIOR TO SEEING THE PHYSICAL THERAPIST
- IF YOU HAVE A **HIGH DEDUCTIBLE POLICY**, **PAYMENT IS DUE AT THE TIME OF SERVICE!**
- IF YOU ARE A NEW PATIENT AND/OR IT HAS BEEN 1 YEAR OR MORE SINCE YOUR LAST VISIT THE FOLLOWING WILL BE REQUESTED:
 - NEW INFORMATION PACKET
 - COPY OF INSURANCE CARD
 - COPY OF PHOTO IDENTIFICATION

IF THIS INFORMATION IS NOT OBTAINED WE MUST RE-SCHEDULE YOUR APPOINTMENT.
(NO EXCEPTIONS)

IT IS YOUR RESPONSIBILITY TO NOTIFY THE RECEPTIONIST IF YOUR INSURANCE COMPANY HAS CHANGED. IF YOU FAIL TO NOTIFY US PRIOR TO YOUR OFFICE VISIT, YOU WILL BE RESPONSIBLE FOR ALL PHYSICAL THERAPY CHARGES ASSESSED. PLEASE DIRECT ANY QUESTIONS REGARDING YOUR INSURANCE TO THE RECEPTIONIST.

THANK YOU!!!

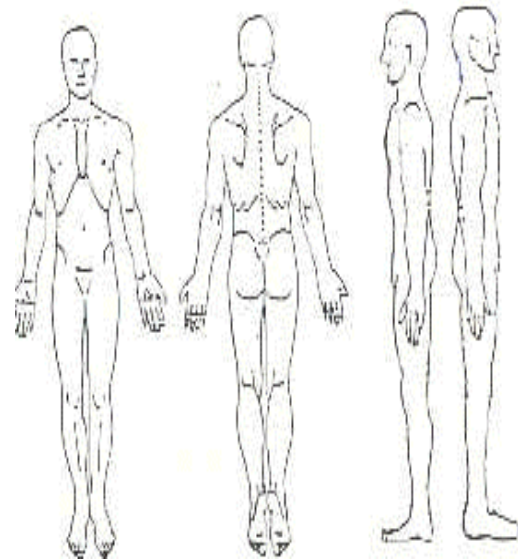
Print Name	Signature	Date
Westlake Physical Therapy, 1220 La Venta Dr. Ste 102, Westlake Village, CA 91361		805-777-7370
Westlake Physical Therapy, 110 Jensen Court, Ste 2C, Thousand Oaks, CA 91360		805-413-1070

Patient Information Record

1. Name: _____
2. Date of onset of symptoms: _____
3. What caused the symptoms? _____
4. What is your biggest complaint? _____
5. What activities could you perform before, that you cannot now due to your condition? _____
6. Do you have any symptoms of tingling, burning or numbness? yes no Where? _____
7. Any changes in Bowel or Bladder function? yes no
8. Which activities make your symptoms worse? _____
9. What makes your symptoms better? _____
10. Do your symptoms change throughout the day? yes no
11. Have you had similar episodes before? yes no
12. Are these episodes increasing in frequency, severity and or character? yes no
13. What is the usual cause for recurrent problems? _____
14. Have you had surgery for this condition? yes no
15. Have you been treated or is any other health care practitioner currently treating these symptoms? yes no
16. If yes, please provide their name (s) and telephone number(s): _____
17. Have you had any recent diagnostic tests performed regarding your present condition (x-rays, MRI, etc.)? yes no
18. If yes, what were the tests and when were they performed? _____

Medical History

1. What medications are you currently taking, if any? _____
2. What allergies do you have, if any? _____
3. Do you have a history of diabetes? yes no
4. Do you have a history of heart disease? yes no
5. Do you have a history of high blood pressure? yes no
6. Is it under control? yes no
7. Have you had previous head trauma or repeated convulsions? yes no
8. Have you had surgery for head, neck or spine? yes no
9. Have you had abdominal surgeries? yes no
10. Have you had any previous shoulder injuries? yes no
11. Have you had any previous knee injuries? yes no
12. Have you had any previous ankle injuries? yes no
13. Have you had any fractures? yes no
14. Are you currently pregnant? yes no
15. Have you been diagnosed with osteoporosis? yes no
16. Have you been diagnosed with rheumatoid arthritis? yes no
17. Do you have a personal history of cancer? yes no
18. Do you have glaucoma? yes no
19. What exercise / sports do you participate in? _____



20. Do you know of any reason why you should not participate in a regular exercise program? yes no if yes, why? _____
21. Is there any other medical condition or diagnosis we should be aware of? yes no if yes, what is it? _____

Signature: _____

Date: _____

Appointment Agreement Form

Our facility would like to emphasize the importance of regularly scheduling and making set appointments. For your health and for the success of your treatment, we ask that you adhere to your Physician and Therapists recommendations for treatment frequency and duration, to the best of your ability.

Cancellation and No-Show Policy

Under the guidelines of this facility a "Cancelled" appointment occurs when a patient gives less than 24 hours notice for canceling or re-scheduling a set appointment. A "No-Show" is when a patient breaks an appointment with no prior notice. Due to the volume of business and our desire to provide patients with the best service possible, every appointment is greatly valued; therefore when appointments are cancelled or broken, our patients, as well as our therapists are at a loss. We know that your time is valuable, and we pride ourselves with prompt and close attention to each of our valued patients. Please in turn be considerate of our time, and keep all scheduled appointments if physically able.

The **first** Cancellation or No-show will be documented in the patients chart. The patient will be made aware of the documentation either in a written or verbal communication from our staff.

Any **continued** instances of Cancellations or No-Shows will be subject to a \$30 fee upon each occurrence, depending on circumstances and Management discretion.

If the behavior is continued to an extent considered inappropriate or unmanageable by the therapist or management, the patient will be discharged from care at this facility and referred back to their Physician.

By signing and dating this form, I acknowledge that I have read and understand the aforementioned procedures and policies of this facility and agree to these terms. I understand that a fee may be applicable for canceling or breaking an appointment according to set guidelines.

Patient Name: _____ Date: _____

Patient Signature: _____

Acknowledgement of Receipt of
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this Physical Therapy office's NOTICE OF PRIVACY PRACTICES. I further acknowledge that a copy of the current notice will be in the reception area of this Physical Therapy office. If amended, I will be provided with a copy of the amended notice will also be available in the reception area updating the original.

Signed: _____ Print Name: _____

Date: _____ Telephone: _____

If not signed by patient please indicate:

_____ Parent/guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of a deceased patient

Name of Patient: _____

NOTICE OF PRIVACY POLICIES

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this practice, but the information in the medical record belongs to you. The law permits us to use and disclose your health information for the following purposes:

- 1. Treatment:** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
- 2. Payment:** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
- 3. Health Care Operations:** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of your professional staff. We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates" such as our billing service, that perform administrative services for us, or our accounting firm in order to meet appropriate bookkeeping requirements for tax reporting purposes. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law, all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, healthcare clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance if health care professionals, their training programs, their accreditation, certification or licensing activities or their health care fraud and abuse detection and compliance efforts.
- 4. Appointment Reminders:** We may disclose your Medical information to contact and remind you about appointments by mail or by phone. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
- 5. Sign in sheets:** We may disclose your medical information by having you sign in when you arrive at our office, or also when we call out your name when we are ready to see you.
- 6. Notification and Communication with family:** We may disclose your medical information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health care professionals will use their judgment in communication with your family and others.
- 7. Marketing:** We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase products or services when we see you. We will not use or disclose your medical information without your written authorization.
- 8. Required by Law:** We may disclose your medical information as required by law but we will limit our use of disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirements set forth below concerning those activities.
- 9. Public health:** We may disclose your medical information as sometimes required by law to health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; or reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
- 10. Health oversight activities:** We may disclose your medical information as sometimes required by law, to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
- 11. Judicial and administrative proceedings:** We may disclose your health information as required by law in the course of any administrative or other judicial proceeding to the extent expressly authorized by a court, administrative order, subpoena, discovery request, or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
- 12. Law enforcement:** We may disclose your medical information as sometimes required by law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and for law enforcement purposes.
- 13. Coroners:** We may disclose your health information as often required by law, to coroners in connection with their investigations of deaths.
- 14. Organ or tissue donation:** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
- 15. Public safety:** We may disclose your health information as sometimes required by law to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
- 16. Specialized government function:** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
- 17. Worker's compensation:** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
- 18. Change of Ownership:** In the event that this medical practice is sold or merged with another organization, your health information record "PHI" will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

B. When this Medical Practice May Not Use or Disclose your Health Information

Except as described in this Notice of Privacy practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights: You have a right to:

- **Obtain a paper copy of this notice of information practices upon request, at any time.**
- **Inspect and copy your health record.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a

reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access psychotherapy notes, you have a right to have them transferred to a mental health professional.

- **Amend or supplement:** You have a right to request that we amend your health information if you believe your health information is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
 - **Right to an accounting of disclosures:** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosure provided to you or pursuant to your written authorization, or as described in paragraphs 1(treatment), 2(payment), 3(health care operations), 6(notification and communication with family) and 16(specialized government functions of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
 - **Right to request Confidential Communications** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
 - **Right to request Special Privacy Protections:** You have right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
- If you have any questions in regards to this notice, please contact our office at (805)777-7370 and ask to speak with a Privacy Officer.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this privacy policy in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy protections will apply to all protected health information that we maintain, regardless of when it was created or received. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request as well as be displayed in the waiting room at our information center.

E. Complaints

Complaint about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer at (805)777-7370

If you are not satisfied with the manner in which this office handles a complaint you may submit a formal complaint to:

Dept. of Health and Human Services:

Office of Civil Rights

Hubert H. Humphrey Bldg

200 Independence Ave. S.W. Room 509F HHH Building Washington, DC 20201

You will not be penalized for filing a complaint.

Initial version: on or before April 23, 2003