La Palma Physical Therapy and Sports Medicine Corporation

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed an how you can get access to information. Please review it carefully.

Legal Duty: La Palma Physical Therapy and Sports Medicine Corporation is required by law to protect the privacy of your personal health information primarily for treatment, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information: La Palma Physical Therapy and Sports Medicine Corporation uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, La Palma Physical Therapy and Sports Medicine Corporation may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

La Palma Physical Therapy and Sports Medicine Corporation may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, La Palma Physical Therapy and Sports Medicine Corporation's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

La Palma Physical Therapy and Sports Medicine Corporation may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights: You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. La Palma Physical Therapy and Sports Medicine Corporation will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints: If you are concerned that La Palma Physical Therapy and Sports Medicine Corporation may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on La Palma Physical Therapy and Sports Medicine Corporation's health information practices, or if you have a complaint, please contact:

La Palma Physical Therapy and Sports Medicine Corporation
Office Administrator
7851 Walker Street, Suite 202
La Palma, Ca 90623
Telephone: (714) 739-4941 ~ Fax: (714) 680-8711

La Palma Physical Therapy and Sports Medicine Corporation

Patient Information

Date:_____

Patient's First Name:_____MI_____ Last Name:_____

Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____Cell/Other: (_____)_____

Date of Birth:_____Age:_____Sex:_____ Marital Status: S M D W

Social Security #:_____ Driver's License#:_____

Present Employer:_____Address:_____

City:_____State:_____Zip:_____

Phone: (_____)_____ Occupation:_____

Name of Spouse:_____Social Security #:_____

Spouse's Employer:_____Address:_____

City:_____State:_____Zip:_____

Phone: (_____)_____ Occupation:_____

Primary Health Insurance Carrier:_____

Name of Insured:_____

Insurance Address:_____City:_____

State:_____ Zip:_____ Phone #:(_____)_____

Group #:_____ Policy #:_____

Secondary Health Insurance Carrier:_____

Name of Insured:_____

Insurance Address:_____City:_____

State:_____ Zip:_____ Phone #: (_____)_____

Group #:_____ Policy #:_____

Patient Information (continued)

Local Friend/Relative not at your address: _____

Address:_____City:_____

Zip:_____ Phone: (_____)_____

Prescribing Physician:_____

Address:_____City:_____

Zip:_____ Phone: (_____)_____Fax: (_____)_____

Referred by:_____

PLEASE READ AND SIGN

I hereby authorize my insurance company to make health benefits payable directly to **LA PALMA PHYSICAL THERAPY AND SPORTS MEDICINE CORPORATION** upon their billing.

_____ _____
Patient Date

I understand that although my insurance company will be billed, I will be responsible for any balance due on my account.

_____ _____
Patient Date

If it becomes necessary for the account to be referred to an attorney for collection or suit, I agree to pay the reasonable attorney fees and collection expenses.

_____ _____
Patient Date

I hereby authorize the above-named facility to release any information acquired over the course of my treatment to designated persons or insurance companies.

_____ _____
Patient Date

(If applicable please sign):
I hereby certify that I was not involved in an auto accident and that there is no third party (insurance or otherwise) involvement.

_____ _____
Patient Date

La Palma Physical Therapy and Sports Medicine Corporation

Patient History Form

PLEASE COMPLETE ALL REQUESTED INFORMATION. USE REVERSE SIDE OF THIS FORM IF NEEDED FOR ADDITIONAL SPACE.

NAME:_____ SEX:_____ DATE OF BIRTH:_____

1. Have you ever had...

High Blood Pressure?	**Yes**	**No**	**Breathing Problems?**	**Yes**	**No**
Heart Trouble?	**Yes**	**No**	**Fractures?**	**Yes**	**No**
Circulation Problems?	**Yes**	**No**	**Stroke?**	**Yes**	**No**
Seizures?	**Yes**	**No**	**Arthritis?**	**Yes**	**No**
Dizzy Spells?	**Yes**	**No**	**Acrophobia?(Fear of heights)**	**Yes**	**No**
Diabetes?	**Yes**	**No**	**Claustrophobia?**	**Yes**	**No**
Other Illnesses?	**Yes**	**No**	**(fear of being confined)**		

2. Have you ever had surgery? Yes No If yes, give date(s), operation(s) and outcome:

_____

_____

_____

3. Do you have metal anywhere in your body (other than your teeth)? Yes No

4. Do you have a cardiac (heart) pacemaker? Yes No

5. (For women only) Are you now pregnant? Yes No
Date of last menstrual cycle? _____

It is your responsibility to notify us immediately if there is any chance you may be pregnant, as some treatments are contra-Indicating if you are.

6. Do you have any trouble with vision? Yes No Hearing? Yes No

7. List any allergies you may have:_____

8. List any medications you are taking: _____

_____

9. Have you ever had physical therapy treatments before? Yes No

If yes, indicate where, when and for what problem:_____

_____

10. Describe briefly the history of your present accident or illness:

_____

_____

_____

Date:_____ Signature:_____
(If not patient, indicate parent, guardian or other)

La Palma Physical Therapy and Sports Medicine Corporation

Patient Information and Consent

I have read and fully understand La Palma Physical Therapy and Sports Medicine Corporation's **Notice of Patient Information Practices.** I understand that La Palma Physical Therapy and Sports Medicine Corporation may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided an any administrative options related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice I also understand that La Palma Physical Therapy and Sports Medicine Corporation will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in La Palma Physical Therapy and Sports Medicine Corporation's **Notice of Patient Information Practices**. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____ _____

Signature Date

La Palma Physical Therapy and Sports Medicine Corporation

Regarding Your Insurance Company

If your insurance claim goes into medical review

Medical Review: A procedure your insurance company uses to establish medical necessity for the treatment of your injury or illness.

Your insurance company may or may not send your claim into medical review. If your claim is sent o review, all prospective insurance payments(s) suspend until a determination for medical necessity is made by your insurance company. Usually, all that is needed to establish medical necessity is a prescription from your doctor, however, some insurance companies require additional information and will request it from your doctor and from our office. Should your insurance company request additional information from your doctor, it is your responsibility to make sure they (the doctor's office) submit the requested information and that it is submitted in a timely manner.

Your decision to continue with physical therapy should your claim go into medical review is your choice. There is always a chance that the insurance company may decide that your treatment is not medically necessary and therefore deny payment on your claim(s). If your claim is denied for any reason, you are responsible for any balance due, unless otherwise directed by the insurance company such as possible contractual adjustment obligations that we have with a particular insurance company.

I,_____ have read and understand the above information regarding medical review on insurance claims.

_____ _____

Signature Date

Cancellation/No-Show Policy

We ask that you try to keep the prescribed treatment program your doctor feels is most appropriate for your condition, as this is vital to your recovery of pain and optimal body function. To help make your visits here more convenient, we schedule our patients in a manner to ensure that there will be minimal waiting time if any. In order to continue with this system, we have instated the following policy:

There will be a standard office visit charge of $58.00 for a cancellation of an appointment less than one hour prior to your scheduled appointment time and/or for failure to show up for your scheduled appointment. In the event of an emergency or situation that prevents you from calling to cancel, you will not be charged. ***Note: Insurance companies do not cover this fee.***

I certify that I have read and understand the above cancellation/no-show policy. In the event that I do not comply with this policy, I agree to promptly remit a $58.00 payment.

_____ _____

Signature Date