Peninsula Physical Therapy
Orthopedic and Sports Physical Therapy
www.peninsulaphysicaltherapy.net

550 Deep Valley Dr. Ste 297
Rolling Hills Estates, CA 90274
Tel: 310-544-6264 · Fax: 310-544-6265

PATIENT INFORMATION

Patient # (office use): P__________

Name: ________________________________ Sex: Male_____ Female_____

Address: ____

City: ____________________________ State: _______ Zip Code: __________

Phone – Home (   ) ____-____ Work (   ) _____ - ____ Cell: (   )_____-____

Email address (optional): ____

Date of Birth: _________________ Social Security #: ______________________

Employer: ____________________ Occupation: ________________________

Spouse or Parent/Guardian

Name: _________________________ Relationship to Patient: ________________

Phone – Home (   ) ____-____ Work (   ) _____ - ____ Cell: (   )_____-____

Referred By:

MD: _______________________ **Friend**: _______________________

Advertisement:
(circle any)

- Peninsula News
- Peninsula People
- Yellow Pages
- Online website
- Insurance company
- Other: ____________________

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT:

Name: ___________________________ Phone: (   ) _______ - _______

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Patient History

Please complete this form completely. This will assist us in properly treating you and identifying possible contraindications for certain treatments. All information provided is held in strict confidence.

- Name: _________________________________
- Date: _____________________
- Birth date: _____________________
- Occupation: ___________________________
- Date of injury, surgery, or onset of complaint(s): _______________________________
- Briefly describe how you were injured or how complains began (i.e. after gardening, lifting, etc.): ____ ____
- Where is your pain/injury located? ____ ____
- Have you had physical therapy before this condition? Yes _____ No_____
- List all prescription and over-the-counter medications you are currently taking for any reason:

  ____
  ____
- If you have a pacemaker, metal implants, or other implants in your body, please describe where they are: ____ ____
- Have you had any of the following diagnostics completed for this condition?

  _____ X-rays
  _____ CT scan
  _____ Electroencephalograph (EEG)
  _____ Myelogram
  _____ MRI
  _____ Electromyography (EMG)
  _____ Arthrogram
  _____Biopsy
  _____ Other (describe): ____
- Are you now under the care or have been under the care of a physician for any of the following disorders?

  _____ Heart problems
  _____ Cancer
  _____ Respiratory problems
  _____ Arthritis
  _____ Allergies
  _____ Eye/Vision problems
  _____ Emotional/Psychological problems
  _____ High blood pressure
  _____ Kidney disease
  _____ Diabetes
  _____ Headaches/Migraines
  _____ Pregnancy
  _____ Sleep problems
  _____ Alcohol/Drug problems
  _____ Other (describe): ____

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ASSIGNMENT OF BENEFITS

Patient's Name: ____

Primary Insurance Company: ____________________________________

ID #: ____

Group # (if needed): ____

Secondary Insurance Company: __________________________________

ID #: ____

Group # (if needed): ____

I hereby authorize Peninsula Physical Therapy to furnish to my insurance carrier(s) any and all requested information concerning my health care.
I also authorize my insurance carrier(s) to pay Peninsula Physical Therapy and/or Mark Argento, MPT, directly for services rendered.

Signed: __________________________________ Date: _______________
(Patient or Legal Guardian)

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NOTICE OF PRIVACY PRACTICES

We protect the privacy of our patient's health information as required by law, practice standards, and our internal policies and procedures. This privacy statement explains your rights, our legal duties, and our privacy practices.

Your Health Information

THIS NOTICE DESCRIBES YOUR MEDICAL INFORMATION ABOUT YOU THAT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We collect, use, and disclose information provided by and about you for medically necessary treatment, health care payments and operations or when we are otherwise permitted or required by law to do so.

For Treatment: We may use and disclose information about you in providing, coordinating, or managing your treatment and wellness activities. We may provide referring physicians, other providers, and other alternative practitioners information about your treatment when they are appropriately involved with the treatment process.

For Payment: We may use and disclose information about you in managing your medical file, to secure treatment authorization, to confirm insurance coverage, for medical billing and receiving payments for medical care through you health plan or other similar entities. We may also provide information to a doctor's office, hospital, or other health care providers or health plans to confirm your eligibility for benefits, medical diagnosis, treatment, and other medically necessary information in order to provide appropriate service and receive payment.

For Health Care Operations: We may use and disclose medical information about you for our operations. For example, we may use information about you to review the quality of care and services you receive; to provide you medical file management or coordination of medical services such as between treating therapists or between doctor and therapist.

As Permitted or Required by Law: Information provided by you may be used or disclosed to regulatory agencies, such during audits, licensure, or other proceedings; for administrative and judicial proceedings; to public health authorities; or to law enforcement officials, such as to comply with a court order or subpoena.

Authorization: Other used and disclosure of protected health information will be made only with your written permission, unless otherwise permitted or required by law. You may revoke this authorization, at anytime, in writing. We will then stop your information for that purpose. However, if we have already used your information based on your authorization, you cannot take back your agreement for those past situations.

Your Rights:
Under regulations that will be used in effect on April 14th, 2003, you will have additional rights over your health information. Under the new rules, you will have the right to:

- Send us a written request to see or get a copy of information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as your physician or hospital.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address if communications to your home address could endanger you.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment, or health care operations, or the law otherwise restricts the accounting. We are not required to give you a list of disclosures made before April 14th, 2003.

Complaints:
If you believe your privacy rights have been violated, you have the right to file a complaint with us, or with the federal government. You will not be penalized for filing a complaint.

Copays and Changes:
You have the right to receive an additional copy of this notice at any time. We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through direct mail.

Contest Information:
If you want to exercise your rights under this notice or if you wish to communicate to us about privacy issue or to file a complaint with us, please contact our privacy office at: **(310) 544-6264**.

Declaration of Privacy of Health Information:
All medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the US Department of Health and Human Services (HHS), and are covered by HIPAA (Health Insurance Portability and Accountability Act of 1996).

Further, I authorize that the results of any assessments or records to me may be used in completing evaluations, assessments, treatment plans, progress reports, summary reports, discharge summary reports and medical billing and reimbursement. I understand that such reports will only report aggregated data, and will only be used for health care purposes such as third party payment and physician or other authorized health care provider treatment or progress reports. I understand I can restrict the uses and disclosure of my medical information. I understand that I have the right to file a formal complaint with a covered provider or health plan or HHS about violations regarding my health and medical records or information.

This release is and shall be binding upon my heirs, assigns, executors, and administrators.

Restrictions requested by patient:

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Signature of Patient: ______________________________ **Date:** ____________________