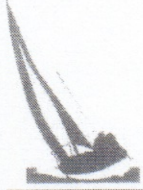


Dana Point Physical Therapy

sports medicine & orthopedic specialists

34241 Pacific Coast Hwy, Ste 102
Dana Point, CA 92629

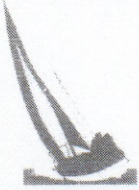
Phone - (949) 496-3896
Fax - (949) 487-0277

Patient Name: (first, last, middle initial)			
Address		City, State, Zip	
HOME PHONE #		Work Phone #	**CELL PHONE #**
Social Security #		**DATE OF BIRTH**	Email Address
Marital Status	**GENDER**	Student?	Employment Status
Occupation		Employer	
Address		City, State, Zip	

Emergency Contact (Name)	Home Phone #	Cell Work Phone #
Address	City, State, Zip	Relationship to Patient

Financially responsible party if not patient must be present

Name		Relationship to Patient
Address		City, State, Zip
Home Phone #		Cell Work Phone #
Social Security #	Date of Birth	Gender



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Cancellation Policy

Dana Point Physical Therapy, Inc. requires a 6 hour cancellation and rescheduling notice. A $45.00 charge will be assessed for no-showed appointments and last minute cancellations. Please phone us at your earliest convenience so that others may fill your appointment.

Thank you in advance!

Patient Signature__________________________________ Date:_________________________

Authorization to Pay Dana Point Physical Therapy

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to DANA POINT PHYSICAL THERAPY and I am financially responsible for non-covered services. I also authorize DANA POINT PHYSICAL THERAPY to release any information to process this claim.

Patient Signature __________________________________ Date: ___________________________

Change of Benefits

If at any time there is a change to your insurance policy or policies, we expect the patient or legal guardian to make DANA POINT PHYSICAL THERAPY aware of these changes.

Patient Signature: __________________________________Date: ___________________________-

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January 1, 2013

2013 Dana Point Physical Therapy Insurance Guidelines

Please initial next to given spaces.
For the effective 2013 year, Dana Point Physical Therapy needs you, the patient, to help us understand and you to acknowledge some key points of your current insurance policy.

While we do our best to help understand the patient's benefits, we need you to recognize that you, as the patient, are fully responsible to know the specifics (deductibles, coinsurances) of your insurance benefits. __________

It is the patient's responsibility to inform Dana Point Physical Therapy of any changes (ID #, group, insurance company, etc) to your policy. ____________

If you have a co-pay, it is to be paid at the point of service, unless otherwise discussed with Jordan or Alli. __________

In the case that your insurance does not pay and/or cover your physical therapy services, we need you to concede that you are fully accountable for payment. ____________

As of January 1, 2013 your primary and/or secondary insurance/s are as follows:

1. ________________________________

2. ________________________________

X______________________________________ date: ___________________

Thank you for your cooperation,

Dana Point Physical Therapy

Dana Point Physical Therapy

Sports Medicine & Orthopedic Specialists

Phone (949) 496-3896 •
Fax (949) 487-0277

History and Physical Condition Information

Answer to the following questions will assist the Therapist in providing a safe and effective treatment program.

Name:______________________ Age:______________

Referring Physician:______________________ Today's Date:______________

Primary Care Physician:______________________ Phone:______________

Problems to be treated:______________________________________

Have you had treatment for 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:______________________________

____

Do you need assistance with any of the following:

Transportation	YES	NO	Meals	YES	NO
Shopping/ Errands	YES	NO	Personal Care	YES	NO
Domestic Chores	YES	NO	Other______________		

Has your illness/ disability caused any of the following:

Financial Problem	YES	NO	Family Problems	YES	NO
Emotional Problems	YES	NO	Other______________		

Have you had Physical Therapy before? YES NO

Are you pregnant? YES NO

List any other major illness or surgery that has occurred in the past year ______________________________

____

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

Signature:______________________ Date:______________

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting, or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse of Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with t he requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal lay, however, you may not inspect or copy the following records; psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to the protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any party of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as describe in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provided individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:________________________ Signature:__________________________ Date: __________________________