



PATIENT INFORMATION

LAST _____ FIRST _____ MI _____
SEX ___ M ___ F BIRTHDATE ___ MO./ ___ DAY/ ___ YEAR SS# _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
PHONE _____ EMAIL: _____
EMPLOYER _____ ADDRESS _____
OCCUPATION _____ WORK PHONE _____ EXT _____
DRIVER'S LICENSE _____ ST _____ MARITAL STATUS _____
WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ WHAT IS YOUR CO-PAY? _____
WHO MAY WE THANK FOR REFERRING YOU? _____
LEAVE A MESSAGE AT YOUR: HOME OFFICE EMAIL OTHER _____

EMERGENCY CONTACT

LAST _____ FIRST _____ RELATIONSHIP _____
ADDRESS _____ CITY _____ ST _____ ZIP _____
HOME PHONE _____ WORK PHONE _____

INSURANCE: PRIMARY

PLEASE COMPLETE ALL INSURANCE INFORMATION COVERING THE PATIENT

NAME _____ ID# _____ GRP NO. _____
INSURED NAME _____ SS# _____ BIRTHDATE ___ MO./ ___ DAY/ ___ YEAR
CIRCLE RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER _____

INSURANCE: SECONDARY

PLEASE COMPLETE ALL INSURANCE INFORMATION COVERING THE PATIENT

NAME _____ ID# _____ GRP NO. _____
INSURED NAME _____ SS# _____ BIRTHDATE ___ MO./ ___ DAY/ ___ YEAR
CIRCLE RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER _____

AUTHORIZATION

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, AND I CONSENT TO ANY MEDICAL TREATMENT RENDERED THE PATIENT UNDER THE GENERAL AND SPECIAL INSTRUCTIONS OF THE PHYSICIAN.

_____ SIGNATURE OF PATIENT

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION RELATED TO MEDICAL SERVICES PROVIDED

I, HEREBY, ASSIGN ALL BENEFITS TO SOUTHLAND PHYSICAL THERAPY, INC. FOR SERVICES RENDERED TO ME OR SAID MINOR PATIENT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME OR SAID MINOR TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE TO SOUTHLAND PHYSICAL THERAPY, INC., AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. I HAVE ALL MY INSURANCE INFORMATION FOR BILLING PURPOSES AND UNDERSTAND THE BILLING PROCEDURES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY INCLUDING BUT NOT LIMITED TO, CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES. I ALSO AGREE TO COMPLETE ALL NECESSARY PAPERWORK IN ORDER FOR MY CLAIM TO BE PAID BY MY INSURANCE COMPANY AND ACCEPT FULL LIABILITY FOR ALL CHARGES IF PAYMENT IS NOT MADE IN MY BEHALF BY MY INSURANCE COMPANY.

SIGNED, PATIENT (OR PARENT IF MINOR) _____ DATE _____

IF OTHER THAN PARENT, RELATIONSHIP _____



SOUTHLAND PHYSICAL THERAPY

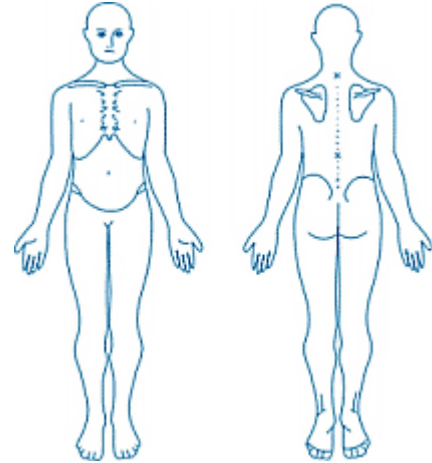
Name: _____ Date: _____ Age: _____

Occupation or previous occupation: _____

Physical Therapy Subjective Information Record

Area(s) of Injury

- A. **Shade** in all areas of your symptoms, Pain, Stiffness, ache etc. on the drawing to the right.
- B. **Label** the spot of your worst pain with a large X.
- C. **Circle** any areas of numbness or tingling.



D. Medical Questions

- 1. Do you have a pacemaker? _____ Yes _____ No
 - 2. Have you experienced significant weight loss recently? _____ Yes _____ No
 - 3. Have you ever had cancer? _____ Yes _____ No
 - 4. Have you had multiple cortisone or prednisone injections? _____ Yes _____ No
 - 5. Are you taking any anti-inflammatory medications? _____ Yes _____ No
 - 6. Are you taking any muscle relaxants for this problem? _____ Yes _____ No
 - 7. Are you taking any pain medications for this problem? _____ Yes _____ No
 - 8. Are you currently taking any other medications? _____ Yes _____ No
- If yes, Please list/explain _____

- 9. Do you have any difficulties with urination? _____ Yes _____ No
- If yes please explain: _____

- 10. What other health care providers are you currently seeing? _____

E. Have you had any of the following for this specific problem:

- CT scans _____ Yes _____ No
- MRI's _____ Yes _____ No
- X-Rays _____ Yes _____ No

Is there any condition not listed above that you feel may affect your treatment in **any way** i.e. Heart condition, Lung condition, Osteoporosis, Joint replacements, Balance deficit, Visual impairment, Previous Surgeries, Skin sensitivity, Allergies, Dizziness, Fainting? Please explain:

I acknowledge that the above information I have written is true and accurate to the best of my knowledge. I will notify my therapist of any change in condition.

Patient Signature

_____/_____/_____
Date



SOUTHLAND PHYSICAL THERAPY

4482 Barranca Pkwy, Suite 195
Irvine, CA 92604
Ph: (949) 679-3337 Fax: (949) 679-3336

Appointment Attendance Policy

It has always been our policy here at Southland Physical Therapy, Inc., to give our patients the benefit of the doubt when they forget to show up for an appointment or cancel an appointment with less than 24 hours notice. However, 3 “no-shows” (missed appointments without prior or any notification) OR cancellations less than 24 hours in advance combined may result in the loss of your physical therapy benefits. We are obliged to notify your referring physician about attendance or compliance problems and your physician may decide to discontinue your course of therapy.

In addition, based on our No-Show or Cancellation Less Than 24 Hours in Advance Policy: There may be a charge for a missed appointment or cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally. Even if it is a last minute cancellation, we greatly appreciate you notifying us so we can attempt to schedule our waiting list patients into your space. If the space is filled with another patient, the charge will not apply to you.

The main reason for this policy is that missed appointments create a hardship on our office and the continuity of your care and other patients. We have patients on our waiting list who are in need of a treatment or evaluation, and they cannot always come in with less than 24 hours notice.

Your commitment to attending your appointments, being there on time, and doing your home exercise program is critical for us to help you heal your injuries.

Thank you!

I understand the above policy, I agree with it, and I will do my utmost best to adhere to it.

Print Name

Signature

Date

Responsible Party if Not Patient

Signature

Date



NOTICE OF PRIVACY PRACTICES

Effective: May 20, 2008

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

Understand your health record and information:

When receiving physical therapy services from SOUTHLAND PHYSICAL THERAPY, INC. a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation, and your treatment plan. It also contains daily treatment notes and progress notes. This record is referred to as your medical record and serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which services can be verified for billing purposes
- A tool for education physical therapy professionals
- A source of data for facility planning
- A tool with which the quality and outcome of care and services given can be evaluated

Our Pledge regarding medical information:

We understand the medical information about you and personal. We are committed to protecting this information. We create a record of care and services you receive. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice applies to the records for your treatment.

How we may use and disclose your medical information:

1. **For treatment:** We may use medical information about you to provide you with treatment. We may disclose this information to your doctors, or other personnel who are involved in your treatment.
2. **For payment:** We may disclose medical information about you so that the treatment you receive may be billed to and payment may be collected from insurance or other benefits that you may be entitled to.
3. **Review for quality care:** We may disclose medical information about you for internal quality check to make sure all of our patients received quality care.
4. **As required by Law:** We will disclose medical information about you when required to do so by federal, state, or local law.
5. **Lawsuits and Disputes:** If you are involved in lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

I have read and understand the information outlined above.

Print Name

Signature

Date

Responsible Party if Not Patient

Signature

Date