State-of-the-Art Physical Therapy

2492 Walnut Avenue, #140 * Tustin, CA 92780
(714)544-2188 * (714)544-2189 Fax
sotapt@sbcglobal.net * www.sotapt.com

Name (Last, First, Middle) _____

Address _____

City, State, Zip _____

Social Security # _____

Date of Birth _____

Phone (home) _____

Phone (wireless) _____

E-mail _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Employer _____

Address _____

City, State, Zip _____

Phone _____

Insured's Name (Last, First, Middle) _____

Address _____

City, State, Zip _____

Social Security # _____

Date of Birth _____

Phone (home) _____

Phone (wireless) _____

E-mail _____

Preferred Appt Confirmation Method (please check one):

Phone ___ E-Mail ___ Text ___

Height _____ **Weight** _____ **Male** _____ **Female** _____

Married _____ **Single** _____ **Divorced** _____

Occupation _____ **Sport(s)** _____

Date of injury _____

Area of injury _____

Referring Doctor _____

Address _____

City, State, Zip _____

Phone _____

Specialty _____

Insurance _____

Address _____

City, State, Zip _____

Phone _____

Policy# _____

I consent to physical therapy services rendered at State-of-the-Art Physical Therapy. Initials_____ I consent to physical therapy services rendered at State-of-the-Art Physical Therapy for my minor child in my absence. Name of minor child_____ Initials_____

I understand that it is my responsibility to inform the physical therapist/staff about any health problems or allergies I have as well as any drugs or medications I am taking. I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist or supportive personnel. I understand that no contract, warranty, guarantee, or promise concerning the results of the physical therapy services is made. Initials_____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed above and certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status or any changes in the above information as soon as possible. I AM AWARE AND UNDERSTAND THAT IF ANY CHECKS ARE MAILED TO MY HOME, I SHALL PROMPTLY DELIVER THE CHECK TO STATE-OF-THE-ART PHYSICAL THERAPY. IF CHECKS ARE NOT DELIVERED, I WILL BE RESPONSIBLE FOR ALL CHARGES IN FULL. I hereby authorize State-of-the-Art Physical Therapy to furnish my insurance carrier or others with full information regarding treatment rendered when so requested. I hereby authorize direct payment of my insurance benefits to State-of-the-Art Physical Therapy, otherwise payable to me, for services rendered. I agree that a copy of this letter is as valid as the original. Initials_____

Signature _____ **Date** _____

State-of-the-Art Physical Therapy
2492 Walnut Avenue, #140 * Tustin, CA 92780
(714)544-2188 * (714)544-2189 Fax
sotapt@sbcglobal.net * www.sotapt.com

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

Cancellation/No Show Policy

I agree to inform State-of-the-Art Physical Therapy of my cancellation by 7:00 PM the business day prior to my appointment. Should I miss my appointment at State-of-the-Art Physical Therapy or fail to inform them within the time frame referenced above, I understand that I will be responsible for a $20 fee per incident.

Patient Name (Print)_____

Patient's Legal Guardian_____

Signature_____ **Date**_____

NOTICE OF PRIVACY PRACTICES

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

This notice takes effect on 2/1/1995 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $25 TOTAL for ~~each page~~, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

State-of-the-Art Physical Therapy

2492 Walnut Avenue, #140 * Tustin, CA 92780
(714)544-2188 * (714)544-2189 Fax
sotapt@sbcglobal.net * www.sotapt.com

Confidential Health History

Medications/Allergies: List all medications you are taking

_____

_____

Surgical History: List all surgeries

_____

_____

Medical History: Check the medical conditions you have or have had in the past

__ AIDS
__ Alcoholism
__ Anemia
__ Anorexia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding Disorders
__ Breast Lump
__ Bronchitis
__ Bulimia
__ Cancer
__ Cataracts
__ Chemical Dependency
__ Chicken Pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Gall Bladder Disease
__ Glaucoma
__ Goiter
__ Gonorrhea
__ Gout
__ Heart Disease
__ Hepatitis
__ Hernia
__ Herpes
__ High Cholesterol
__ HIV Positive
__ Kidney Disease
__ Liver Disease
__ Measles
__ Migraine Headaches
__ Miscarriage
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate Problem
__ Psychiatric Care
__ Rheumatic Fever
__ Scarlet Fever
__ Stroke
__ Suicide Attempt
__ Thyroid Problems
__ Tonsillitis
__ Tuberculosis
__ Typhoid Fever
__ Ulcers
__ Venereal Disease

Symptoms: Check the symptoms you currently have or have had in the past year

GENERAL:
__ Chills
__ Depression
__ Dizziness
__ Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Loss of weight
__ Nervousness
__ Numbness
__ Sweats

CARDIOVASCULAR:
__ Chest pain
__ High blood pressure
__ Irregular heartbeat
__ Low blood pressure
__ Poor circulation
__ Rapid heartbeat
__ Swelling of ankles
__ Varicose veins

MUSCLE/JOINT/BONE:
(pain, weakness, numbness in)
__ Arms
__ Legs
__ Hands
__ Feet
__ Neck
__ Back

GENITO-URINARY:
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination

SKIN:
__ Bruise easily
__ Hives
__ Itching
__ Change in moles
__ Rash
__ Scars
__ Sores that won't heal

GASTROINTESTINAL:
__ Appetite poor
__ Bloating
__ Bowel changes
__ Constipation
__ Diarrhea
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal bleeding
__ Stomach pain
__ Vomiting including blood

WOMEN:
__ Breast lump
__ Extreme menstrual pain
__ Hot flashes
__ Currently pregnant

EYE, EAR, NOSE THROAT:
__ Bleeding gums
__ Blurred vision
__ Crossed eyes
__ Difficulty swallowing
__ Double vision
__ Earache
__ Ear discharge
__ Hay fever
__ Hoarseness
__ Loss of hearing
__ Nosebleeds
__ Persistent cough
__ Ringing in ears
__ Sinus problems
__ Vision – flashes or halos

HISTORY OF FALLS:
__ No
__ Yes
Date of last fall:_____

CURRENTLY RECEIVING HOME HEALTH CARE:
__ Yes
__ No Date discharged from home health care:_____

*Interested in weight loss? Yes No
*Interested in nutritional supplements for optimal health? Yes No

State-of-the-Art Physical Therapy has my authorization to request from a personal physician, hospital, clinic, etc. information regarding my medical history, physical condition or diagnosis when deemed necessary.
To the best of my knowledge, the foregoing are correct and complete.

Name_____ Date_____

State-of-the-Art Physical Therapy
2492 Walnut Avenue, #140 * Tustin, CA 92780
(714)544-2188 * (714)544-2189 Fax
sotapt@sbcglobal.net * www.sotapt.com

HOW DID YOU FIND OUT ABOUT US?

This information is used to help us service our clients better.
(Please Print)

Your Name: _____ Date: _____

(Please Check and Complete all that Apply)

- ☐ Referred by a friend or family member. Name: _____
- ☐ Referred by Dr or other health care professional: Name: _____
- ☐ Referred by a current or former patient of SOTA PT. Name: _____
- ☐ Former Patient
- ☐ Web site search. Search term: _____

Browser used (circle one): Google / Yahoo / Bing / Chrome / Other

Web site or web link (check all that apply):

- ☐ www.sotapt.com (Organic Search)
- ☐ Yelp Link
- ☐ Alter G Website Link
- ☐ K-Laser Website Link
- ☐ Other Website Link: Name: _____
- ☐ Other Method (Building Sign, Etc): _____