



Patient Information Form

Patient Information

Last Name: First Name: MI:
Address:
Home Phone: Work Phone: Cell Phone:
Date of Birth: SSN: Gender: Marital Status:
Email:

Emergency Contact

Last Name: First Name:
Relationship: Phone:

Employer

Name: Phone:
Address:
City State Zip Code

Problem

Problem description: Date of Injury:
Last Physician Visit: Referred by:
Primary Care Physician: Motor Vehicle Accident:
That occurred in:

Primary Insurance

Insurance: Deductible: Subscriber Name:
ID: Max Benefit: Relationship:
Group #: CoPay: CoInsurance: Date of Birth:

Secondary Insurance

Insurance: Deductible: Subscriber Name:
ID: Max Benefit: Relationship:
Group #: CoPay: CoInsurance: Date of Birth:

Tertiary Insurance

Insurance: Deductible: Subscriber Name:
ID: Max Benefit: Relationship:
Group #: CoPay: CoInsurance: Date of Birth:

I understand and agree that , (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers.

I certify this information is true and correct to the best of my knowledge. I consent to have Pine Street Physical Therapy and/or its affiliates provide the treatment and care prescribed by my physician(s).

Signature: Date:

Medical History Intake Form

Patient Name: _____ Age: _____ Occupation: _____

What is the reason for your visit today? _____

Have you **EVER** been diagnosed as having any of the following conditions?

- | | | | | | |
|-----|----|--|-----|----|--------------------------|
| YES | NO | Cancer. If YES, what kind/when: _____ | YES | NO | High Blood Pressure |
| YES | NO | Heart Problems. If YES, what kind: _____ | YES | NO | Rheumatoid Arthritis |
| YES | NO | Tuberculosis | YES | NO | Multiple Sclerosis |
| YES | NO | Hepatitis | YES | NO | Osteoporosis |
| YES | NO | Polio | YES | NO | HIV/AIDS |
| YES | NO | Stroke. If YES, when: _____ | YES | NO | Diabetes |
| YES | NO | Migraines | YES | NO | Depression |
| YES | NO | Fibromyalgia | YES | NO | Cirrhosis/ liver disease |
| YES | NO | Kidney Disease. If YES, what kind: _____ | YES | NO | Asthma |
| YES | NO | Blood Clots | YES | NO | Epilepsy |
| YES | NO | Thyroid Problems | YES | NO | Pneumonia |
- Other: _____

Surgeries/Hospitalizations Include Approximate Date and Reason:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Please list any medications you are taking (prescription or over the counter):

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Do you have (please circle)?

Pacemaker Transplanted organ Joint replacements Metal Implants

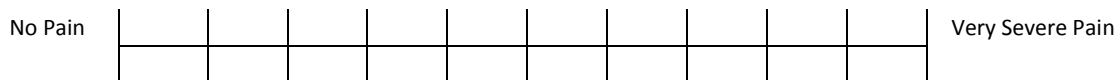
Have you had any tests for this current problem (please circle): XRAY MRI CT Scan LAB

Tobacco use: How many packs do you smoke per day _____ for how many years _____? If quit, when? _____

Have you **recently** noted?

- | | | | | | | | | |
|-----|----|------------------------------|-----|----|---|-----|----|-----------------------|
| YES | NO | Unexplained weight loss/gain | YES | NO | Nausea/Vomiting | YES | NO | Fatigue |
| YES | NO | Dizziness/lightheadedness | YES | NO | Weakness | YES | NO | Tremors |
| YES | NO | Fever/Chills/Sweats | YES | NO | Numbness/Tingling | YES | NO | Seizures |
| YES | NO | Double Vision/Loss of Vision | YES | NO | Skin Rash | YES | NO | Problems Sleeping |
| YES | NO | Night sweats | YES | NO | Blood in Stools | YES | NO | Urinary Incontinence |
| YES | NO | Hearing Problems | YES | NO | Easy Bruising | YES | NO | Joint/Muscle Swelling |
| YES | NO | Excessive Bleeding | YES | NO | Difficulty breathing | YES | NO | Constipation/diarrhea |
| YES | NO | Blood in the urine | YES | NO | Regular Cough | YES | NO | Arm/Leg swelling |
| YES | NO | Heartburn/indigestion | YES | NO | Pregnant or think you might be pregnant | | | |

How severe is your pain today? Place a vertical mark on the line below to indicate how bad you feel your pain is today.



Patient Signature

Date



Notice of Privacy Practices
Pine Street Physical and Occupational Therapy
534 E. Pine Street, Suite A
Stockton, CA 95204
Nancy Mize, Office Manger/Privacy Officer
(209) 463-5800

Effective Date: _____

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our “business associates”, such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information, which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making

these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. **Marketing.** We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. **Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement official, we will further comply with the requirement set forth below concerning those activities.

9. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. **Health oversight activities:** We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. **Judicial and Administrative Proceedings:** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. **Law Enforcement:** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. **Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. **Organ or tissue donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. **Public Safety.** We may, and are often required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
17. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
18. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
19. **Research.** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
20. **Death Certificates.** We may disclose your health information as necessary to comply with death certification laws. For example, the law requires physicians within fifteen hours after the death of a patient to deposit the death certificate at the place of death, or deliver it to the attending funeral director at his place of business or at the office of the physician.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitation on our use or disclosure of that information you wish to have imposed. However, we reserve the right to accept or reject your request, and will notify you of our decision.
2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Request Copy of Chart.** You have the right to request a copy or have an outside copy service copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to get a copy of it or hire an outside copy service copy your health information for you. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely cause substantial harm to your child, you will have a right to appeal our decision. If

we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and who you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident or a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. **You have the right to a paper copy of this Notice of Privacy Practices.**

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices.

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and you may request an additional copy from the reception desk. In the future when our website is activated, we will also post the current notice on our website.

E. Complaints.

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: (You will not be penalized for filing a complaint).

**Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington DC, 20201**



Acknowledgment of Receipt of Notice of Privacy Practices

**Pine Street Physical and Occupational Therapy
534 Pine Street, Suite A
Stockton, CA 95204**

**Nancy Mize, Office Manager
Privacy Officer
(209) 463-5800**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed

Date

Print Name

Telephone Number

If not signed by patient, please indicate:

Relationship:

____ Parent or guardian of minor patient

____ Guardian or conservator of an incompetent patient

Name of Patient