ST. MARINA PHYSICAL THERAPY
113 Waterworks Way Suite 230 Irvine Ca, 92618
Tel: (949)770-1911
Fax: (949)770-1985

Patient Information

Patient Last Name First Name		Date of Birth	Male ☐ Female ☐	Marital Status Single ☐ Married ☐ Other ☐
Home Address			S.S #	
Email	Cell Number	Home Number	Work number	
Employer Name		Occupation		
Employer Address			Student Full Time ☐ Part Time ☐	
Name of Emergency Contact		Relationship	Phone Number	

Case Information

Injury Description			Auto ☐ Work ☐ Injury or Symptoms Started	Date of Surgery
Referring Physician	Physician Phone	Name of Additional physician		2nd Physician Phone

Insurance Information

Type of Insurance
Private ☐ Medicare ☐ Worker Comp ☐ Auto ☐ Other ☐_____

Primary Insurance	Policy ID	Group Number	
Secondary Insurance	Policy ID	Group Number	
Name of Insured	Relationship	DOB	Phone Number
W.C Claim Number	Adjuster Name	Num of Visits	Phone Number
Attorney Name	Phone Number	Fax	
Attorney Address			

I authorize the release of any medical or other information necessary to process claims on my behalf. I also agree to be fully responsible for all lawful debts incurred by myself for services received from Saint Marina Physical Therapy Inc, and consent to medical treatment, whether covered by insurance or not.

Signature :_____ Date: _____

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Patient Medical History Form

Name: _____ Age _____

Date of Onset: Injury / Problem / Surgery: _____

Briefly state previous treatment, if any:_____

Do you have now, or have you ever had, any of the following?

Diabetes	YES ☐ NO ☐	Allergy to Cold	YES ☐ NO ☐
High Blood Pressure	YES ☐ NO ☐	Other Allergies	YES ☐ NO ☐
Pacemaker	YES ☐ NO ☐	Previous Surgery	YES ☐ NO ☐
Chronic Headaches	YES ☐ NO ☐	Seizures	YES ☐ NO ☐
Kidney Problems	YES ☐ NO ☐	Metal Implants	YES ☐ NO ☐
Nervous Disorders	YES ☐ NO ☐	Dizziness	YES ☐ NO ☐
Hernia	YES ☐ NO ☐	Cancer	YES ☐ NO ☐
Osteoporosis	YES ☐ NO ☐	Bone Disease	YES ☐ NO ☐
Bowel Problems	YES ☐ NO ☐	Recent Weight Loss	YES ☐ NO ☐
Fractures	YES ☐ NO ☐	Circulatory Disease	YES ☐ NO ☐
Bladder Problems	YES ☐ NO ☐		
Pins and Needles	YES ☐ NO ☐		

Problems with both arms and both legs at the same time YES ☐ NO ☐

If yes to any of the above, please explain and give appropriate details:

_____

_____

Are you pregnant now?YES ☐ NO ☐

Are you presently taking any medication? YES ☐ NO ☐

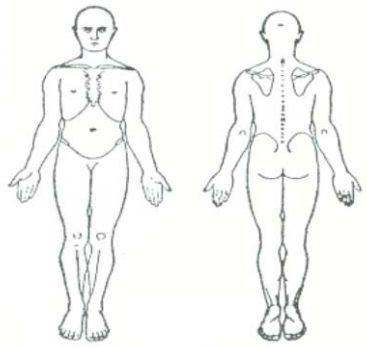
If yes, please list your medications
and for what condition:

_____

_____

_____

Where is your pain?



Have you had any X-rays, CAT scans, MRIs,
or other diagnostic tests for your recent disorder?
YES ☐ NO ☐ If YES, please explain the findings as you understand them

_____

_____

Is there anything else you think I should know about your general health, or current condition?
Please explain and, if necessary, we can talk about it: _____

_____

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We attribute our success to the policies and beliefs we uphold.

General Patient Policies

- **Do not be late.** If you are more than 10 minutes late to your appointment you may be asked to reschedule.
- **Give 24-hr advance notice**. A $10 fee will be applied to your account for any reschedules or cancellations made with a less than 24 hour advance notice.
- **No-Shows are bad.** We understand things happen. If you are unable to keep your appointment please call and let us know. Simply not showing up will result in the loss of all previously scheduled future appointments. New appointments will be allowed on a "first-come, first-serve" basis.
- **Turn cell-phones OFF**. No cell phone or telephone calls during treatment time.

Patients Signature: _____

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Financial Policy

Patient Name :_____ DOB:_____

We Thank you for taking the time to read our Policy, if you have any questions please don't hesitate to ask us.

Patient's Responsibility

We bill your personal insurance carrier as a courtesy to you , please be aware of your benefits and if you are unsure of your plan we recommend that you contact your carrier directly.
If a payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the Payment(s) to us.
If there is a balance owing on the account please pay promptly upon the receipt of the statement.
It is also the Patient's responsibility to understand that if the insurance benefits or eligibility are NOT APPOROVED by the health Plan then you are responsible for the all charges related to services provided.
A photo copy of this signature is valid as the original (Under California State Insurance Code #10133).
Authorize the release of any information necessary to secure the payments of Benefits

For Medicare Patients

Are you Currently Receiving In-Home health Services? Yes □ No □

Medicare does not allow you to receive both in-home care and outpatient care at the same time.

If at any time during your treatment of physical therapy you begin to receive in-home care, you will be held financially responsible for the treatment acquired from St. Marina Physical therapy.

Patient's Signature: _____ Date: _____

Parent or Authorized Representative: _____

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Statement of Privacy Notice

Effective September 1, 2006

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 may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child 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.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may 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 or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary 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 to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (949) 770-1911. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (949) 770-1911. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide St Marina Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____

Patient's Name (print)

_____

Patient's Signature Date

_____

Authorized Facility Signature Date