

Effective: March 2003

Paulseth & Associates Physical Therapy, Inc NOTICE OF PATIENT INFORMATION PRACTICES

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

Legal Duty

Paulseth & Associates Physical Therapy, Inc is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Paulseth & Associates Physical Therapy, Inc uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Paulseth & Associates Physical Therapy, Inc may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Paulseth & Associates Physical Therapy, Inc may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Paulseth & Associates Physical Therapy, Inc will obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Paulseth & Associates Physical Therapy, Inc may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Paulseth & Associates Physical Therapy, Inc will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Paulseth & Associates Physical Therapy, Inc may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Paulseth & Associates Physical Therapy, Inc health information practices or if you have a complaint, please contact the following person:

Paulseth & Associates Physical Therapy, Inc

Karen Snider, Office Administrator
1950 Century Park East Los Angeles, CA 90067
Telephone: 310/286-0447 Fax: 310/286-1224

PAULSETH & ASSOCIATES PHYSICAL THERAPY, INC.

PATIENT NAME: _____

1. Information Consent Form

I have read and fully understand Paulseth & Associates Physical Therapy, Inc.'s Notice of Information Practices. I understand that Paulseth & Associates Physical Therapy, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ABC PT/OT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Paulseth & Associates Physical Therapy Inc.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient/Guardian Signature: _____ Date: _____

2. Cancellation/Missed Appointment Policy

Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours advance notice so that we may reschedule your appointment and offer the reserved time to another patient. You will also avoid incurring a "cancellation" or "no show" charge. I understand that I may be personally responsible for a charge \$30.00 for any cancelled or no show appointment with less than 24 hours advance notice. I understand that my insurance company does not take responsibility for cancelled or no show appointments and that I am personally responsible for such charges.

Patient/Guardian Signature: _____ Date: _____

3. Authorization for Signature on File and Release Information

I, the undersigned, hereby authorize the office of Paulseth & Associates Physical Therapy, Inc. to affix my name to any and all claims or documents as related to any and all health benefits due to me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as the original.

Patient/Guardian Signature: _____ Date: _____

4. Authorization for Assignment of Benefits/Financial Responsibility

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Paulseth & Associates Physical Therapy, Inc., and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance.

Patient/Guardian Signature: _____ Date: _____

5. Prior Used Visits

I understand that my insurance carrier may have a limitation on physical therapy that I receive. It is therefore, my obligation to disclose to Paulseth & Associates Physical Therapy, Inc. whether I have received any physical therapy, occupational therapy, speech therapy, acupuncture, or chiropractic treatment prior to my treatment with them.

_____ No, I have not received prior treatment _____ Yes, I have received prior treatment

Please state below what prior treatment, date of service and how many visits you have received:

6. Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Paulseth & Associates Physical Therapy, Inc. to furnish care and treatment considered necessary and proper in treating my condition.

Patient/Guardian Signature: _____ Date: _____

Paulseth & Associates Physical Therapy, Inc.
Patient Registration Information

Patient Information

Last Name _____ First Name _____ Home Phone _____
Address _____ Apt. No. _____ Birth Date _____
City _____ State _____ Zip Code _____ SS# _____
Employer _____ Occupation _____ Work Phone _____
Employers Address _____ City _____ State _____ Zip Code _____
Email _____ State _____ Referred By _____ Date of Injury _____

Emergency Information

Name of Local Friend or Relative _____
Relationship _____ Address _____ City _____
State _____ Zip Code _____ Phone _____

Insurance Information

Primary Insurance Name _____ Secondary Insurance _____
Address _____ Address _____
Policy No. _____ Group No. _____ Policy No. _____ Group No. _____
Name of Insured _____ Name of Insured _____
SS# _____ SS# _____

Assignment of Benefits

I HEREBY INSTRUCT AND DIRECT _____ INSURANCE COMPANY TO PAY DIRECTLY TO PAULSETH AND ASSOCIATES PHYSICAL THERAPY FOR THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER, OR ATTORNEY INVOLVED IN THIS CASE.

Date _____ Signed _____

PATIENT HISTORY

Name: _____ Sex: _____ Date of Birth: _____

Please complete all requested information.

Have you ever had?: (If Yes, please explain)

High Blood Pressure	Yes	No	_____
Heart or Circulation Disorders	Yes	No	_____
Seizures	Yes	No	_____
Dizzy Spells	Yes	No	_____
Diabetes	Yes	No	_____
Cancer	Yes	No	_____
Arthritis/Osteoarthritis	Yes	No	_____
Osteoporosis	Yes	No	_____
Immune Deficiency Disease	Yes	No	_____
Other	Yes	No	_____

Please list surgeries you have had; please give procedures and dates, if possible: _____

Please list recent diagnostic studies (Cat-scan, MRI, X-rays): _____

Do you have any METAL anywhere in your body; pins/plates post fracture, or pacemaker (other than teeth)? No-Yes. Describe: _____

(For women only) Are you now pregnant?

Do you have any abnormal trouble with vision? No-Yes / Hearing? No-Yes

List any Allergies you have: _____

Have you ever taken steroids or anti-coagulants for an extended period of time: No-Yes

Have you had an unusual weight gain or loss lately? No-Yes

List medications you are now taking: _____

Have you ever had physical therapy treatments before: No-Yes

If Yes, please indicate where, when, and for what problem:

Describe briefly the history of your present ACCIDENT, INJURY, OR ILLNESS:

Onset date: _____ Description: _____

Date of next Doctor appointment:

Patient Signature: _____

PAULSETH & ASSOCIATES PHYSICAL THERAPY, INC

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date



Name _____

How did you learn about our clinic?

- Website (paulsethpt.com)**
- Insurance List of Providers**
- Friend/Colleague** _____
- Doctor Referral** _____
- Belong to Meridian and Noticed Clinic**
- Television**
- Other** _____