

**Los Alamitos Orthopedic
& Sports Physical Therapy**

4226 Katella Avenue • Los Alamitos, CA 90720
Office: 562-431-6004 • Fax: 562-431-9854



**Newport Physical Therapy &
Sports Rehabilitation Center**

369 San Miguel Drive, Suite 265 • Newport Beach, CA 92660
Office (949) 644-2022 • Fax: (949) 644-1914

PATIENT INFORMATION

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Telephone _____ Email Address _____
 Social Security # _____ Driver Lic. # _____
 Age _____ Date of Birth _____ Sex _____ Status: Married Single Widow Divorced No. Children _____
 Occupation _____ Employer _____ Years Employed _____
 Employer's Address _____ City _____ State _____ Zip _____
 Occupation _____ Employer _____ Phone _____
 Person Responsible for this Account _____ Spouse's Name _____
 Referring Doctor's Name _____ Referred By _____

What are your major complaints? _____

Is this condition getting progressively worse? Yes No
 Is this condition interfering with your: Work Sleep Daily Routine Other _____
 How long has it been since you really felt well? _____
 List and date surgical operations: _____

Do you have one of the following: Pacemaker Metal Implant Other: _____
 What other types of doctor/health care providers have you seen for this condition? _____
 Results _____ Length of time under care _____
 Were you off work? _____ If so, how long _____ Have you returned to your same job? ___ If not, why _____
 Are you receiving home health care? _____

CONTINUED ON THE BACK SIDE OF THIS PAGE

ACCIDENT INFORMATION

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No
 Date _____ Time _____ injury reported to employer. Name of Supervisor _____
 Description of accident _____
 Details of injury _____
 Location _____
 Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____
 Patient taken to _____ Hospital for _____ Treatment _____
 Hospitalized for _____ Days _____ Hours. Name of hospital doctor _____
 Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None
 Describe _____
 Do you have an attorney? Yes No Name & Address _____

PATIENT'S, INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the undersigned physician or supplier for the services described above. I request payment of government benefits either to myself or to the party that accepts assignment. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____

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PATIENT INFORMATION

Name _____ Patient's age _____

Doctor's name _____

Date of last MD visit _____

What activities would you like to return to doing?

PATIENT HISTORY

How did the pain start?

- Suddenly Pulling
- Gradually Injured at work
- Lifting Bending
- No apparent reason Other _____

What activities make the pain worse?

- Exercise (during) Bending forward
- Exercise (after) Bending backwards
- Sitting Coughing
- Walking Sneezing

What reduces the pain?

- Lying down Pain pills
- Sitting Injection for pain
- Standing Muscle relaxants
- Walking Nothing
- Anti-inflammatories Other _____

How long have you had this pain?

_____ Years _____ Months _____ Weeks

Have you had any of these diagnostic tests?

- X-rays Yes No Date _____
- CT scan Yes No Date _____
- EMG/NCV Yes No Date _____
- MRI Yes No Date _____
- Arthrogram Yes No Date _____
- Injections Yes No Date _____

Have you been hospitalized for your problem?

Yes No Date _____

Have you had surgery for your problem?

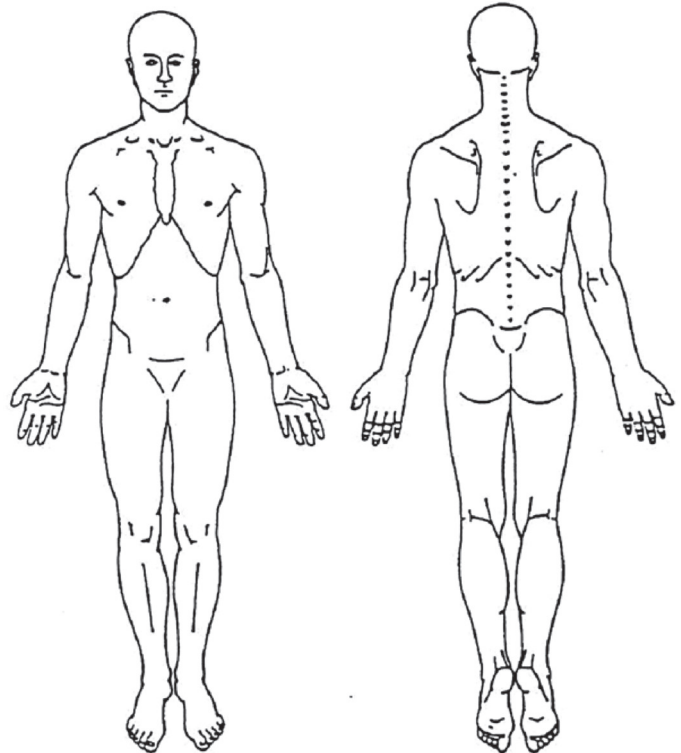
Yes No Date _____

Medication: _____

PAIN & SYMPTOMS

On the Body Diagram, indicate your region of pain and level (0-10) using the symbols below:

(X) Sharp (+) Numb/Tingling (#) Dull/Aching (B) Burning



Do you have any of the following:

- | | Yes | No | | Yes | No |
|------------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Night sleep disturbance | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | History of fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Lack of bladder or bowel control | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke (CVA) | <input type="checkbox"/> | <input type="checkbox"/> | Increased thirst or hunger | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer or tumors | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung problems | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion or heartburn | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis-joint difficulties | <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| (Ir) regular headaches | <input type="checkbox"/> | <input type="checkbox"/> | Changes in memory | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness-blackouts | <input type="checkbox"/> | <input type="checkbox"/> | Unusual fatigue-weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures-nerve disorders | <input type="checkbox"/> | <input type="checkbox"/> | Fever or chills | <input type="checkbox"/> | <input type="checkbox"/> |
| Visual problems | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or easy bruising or bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Menstrual problems | <input type="checkbox"/> | <input type="checkbox"/> | Frequent cramping | <input type="checkbox"/> | <input type="checkbox"/> |
| Immunity disorders | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | | | |



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 April 15, 2003 and remains in effect until we replace it.

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.

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 notice that is now in effect.

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 change.

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.

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.

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.

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 facilities' directories: your name, your location in our facility. We may disclose this information to qualified members of our staff, to others who contact us and ask for information about you by name.

Notification: 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, or medical information for you.

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

Research in limited circumstances: 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.

Sawyer, Einhorn & Mandas Rehab Associates Inc.
dba: Los Alamitos Sports Physical Therapy
4226 Katella Ave. Los Alamitos, CA 90720
(562) 431-6004



NOTICE OF PRIVACY PRACTICES

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 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 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 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 and 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.

You Have a Right to:

1. Look at or get copies 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 \$1.00 per 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 your medical information. We 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 your 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 Privacy Officer at your office.

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 & Human Services. We will not retaliate in any way if you choose to file a complaint. Privacy Officer: Tori Pickerel 562 431-6004

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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

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

Name: _____

Birthdate: ___/___/___

Signature: _____

Date: _____