



RANCHO PHYSICAL THERAPY
INFORMACION DEL PACIENTE

Fecha: _____

Nombre: _____ Seguro Social: _____
Primer Inicial Apellido (REQUERIDO PARA COMPENSACION AL TRABAJADOR)

[] Masculino [] Femenino Fecha de Nacimiento: ___/___/___ Estado Civil: [] Soltero [] Casado [] Divorciado [] Viudo

Domicilio: _____
Calle Ciudad Estado Codigo Postal

Correo Electronico: _____ Fax: (____) _____ - _____

Le gustaria recibir recordatorios de citas por correo electronico? [] Si, notificarme por e-mail [] No enviar e-mail

Telefono de Casa: (____) _____ - _____ [] Trabajo o [] Celular (____) _____ - _____

Le gustaria recibir recordatorios de citas por mensaje de texto? [] Si, notificarme por texto. [] No enviar texto

Licencia de Manejo: _____ Estado: _____ Favor de facilitar copia para nuestros archivos .

Empleador: _____ Oficio: _____
(REQUERIDO PARA LOS CASOS DE COMPENSACION AL TRABAJADOR)

Contacto de Emergencia _____ Telefono: (____) _____ - _____ Parentesco: _____

INFORMACION DEL MEDICO

Medico de referencia: _____ Fecha de lesion actual: _____

Domicilio de oficina: _____ Telefono: (____) _____ - _____
Calle Ciudad Estado Codigo Postal

POLIZA DE CITAS

Entiendo que mi medico ha prescrito terapia para mi y que la terapia fisica es un proceso continuo que requiere de la asistencia regular, para que sea optimamente eficiente. Entiendo que si llego tarde a mi cita, puede que tenga que hacer otra cita o aceptar un tratamiento mas corto por ese dia. Entiendo que si cancelo o no me presento a 3 citas consecutivas, Rancho Physical Therapy reserva el derecho de suspender los tratamientos por no cumplir con las ordenes de mi medico.

Estoy de acuerdo y entiendo que Rancho Physical Therapy necesita previo aviso de 24 horas para cancelar citas. Entiendo que si no doy aviso con 24 horas de anticipacion, para cancelar mi cita, puedo recibir un cargo de \$25 dolares (lo cual no es cubierto por mi aseguranza).

Firma: _____ Fecha: _____
(Si el paciente es menor de 18 anos, los padres o guardian legal debe firmar)

Relacion con el Paciente: MADRE PADRE GUARDIAN LEGAL

AUTORIZACION PARA TRATAMIENTO

Entiendo y estoy de acuerdo al autorizar los tratamientos de terapia, lo cual en conjucion con el juicio de mi medico, puede ser considerado necesario y/o recomendable para el diagnostico y/o tratamiento del paciente nombrado arriba en Rancho Physical Therapy, Inc.

Firma: _____ Fecha: _____
(Si el paciente es menor de 18 anos, los padres o guardian legal debe firmar)

Relacion con el Paciente: MADRE PADRE GUARDIAN LEGAL

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

Rancho Physical Therapy

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

If you have any questions about this notice, please contact our Privacy Officer: Jenny Norton

WHO WILL FOLLOW THIS NOTICE

This notice describes Rancho Physical Therapy and that of:

- Any health care professional authorized to enter information into your chart.
- All departments of the practice.
- Any member of interns, students or observers we allow to help you while you are at our practice.
- All employees, staff and other practice personnel.

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

TEACHING NOTICE

Rancho Physical Therapy is a teaching facility. All patient care is overseen and supervised by an attending physical therapist. Residents, fellows, students and graduate students of physical therapy schools may participate in examinations or treatment of patients as a part of the health care education programs of the institution. Each student or observer will abide by all privacy practices of Rancho Physical Therapy and HIPAA rules and regulations.

Prior to observation, attending Physical Therapists must obtain each patient's consent (either verbally or in writing) to the presence of the Student or Observer and document such consent in the patients' health record.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your physicians or others working in this office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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 other therapists, doctors, nurses, technicians, or medical students who are involved in taking care of you in our practice. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members. We may also disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Notice of Privacy Practices

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your care received so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of medical information so others may use it to study health care delivery without learning who our specific patients are.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care.

Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you.

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct at our facility.
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Notice of Privacy Practices

Coroners, Medical Examiners, and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the attention of: Jenny Norton Privacy Officer, Rancho Physical Therapy PO BOX 870 Murrieta CA. 92564. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. Rancho Physical Therapy charges \$15 for searching and handling. You will receive your copy within 30 days of receipt of your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the practice. To request an amendment, your request must be made in writing and submitted to the Corporate Office Manager. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the medical information kept by this practice.
- Is not part of the information, which you would be permitted to inspect and copy.
- Is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list or accounting of disclosures, you must submit your request in writing to the Corporate Office Manager. Your request must state a time period, which may not be longer than seven years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had to your spouse.

Notice of Privacy Practices

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Corporate Office Manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Corporate Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date on the first page, second line from the top.

COMPLAINTS

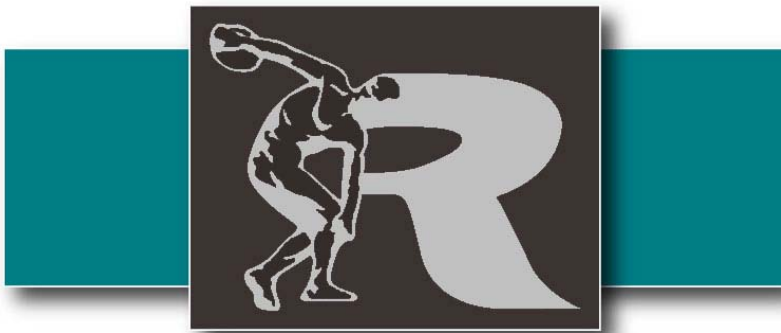
If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact:

Jenny Norton
Privacy Officer
PO Box 870
Murrieta, CA 92564
(951)303-9566.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



**PF-2000 ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

RANCHO PHYSICAL THERAPY reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for RANCHO PHYSICAL THERAPY.

NAME OF PATIENT: _____
(Please Print)

SIGNATURE OF PATIENT: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

RELATIONSHIP TO PATIENT: SELF MOTHER FATHER LEGAL GUARDIAN

Date: _____

OFFICE USE ONLY (If above not signed)

**PF-2100 Documentation of Attempt to Obtain Acknowledgement of
Receipt of Notice of Privacy Practices**

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices.

The acknowledgement was not obtained because:

The patient declined to sign the acknowledgement.

Other _____

Name of Patient (Please Print)

Name of RPT Employee

Date



RANCHO PHYSICAL THERAPY

POLIZA FINANCIERA Y INFORMACION DE ASEGURANZA

Entiendo y estoy de acuerdo que las formas de cargos para mi aseguranza seran presentadas a mi compania de aseguranza como una cuestion de conveniencia solamente y que soy responsable por todos los gastos sin tomar en cuenta mi cobertura medica existente. Entiendo que soy responsable por todas las provisiones, como aparatos de adaptacion o equipo de ejercicio, que me proporcionen durante el tratamiento, si ellos no son cubiertos por mi plan de aseguranza. Yo entiendo que debo pagar por las provisiones al momento que las reciba, y que Rancho Physical Therapy, Inc. (RPT) le mandara el cobro a mi compania de aseguranza y me reembolsaran cualquier saldo restante.

Por este medio doy autorizacion para que RPT reciba los pagos directamente de los beneficios de mi aseguranza por los servicios recibidos. En caso de que mi compania de aseguranza me envie el pago por los servicios obtenidos, en lugar de enviarlos a RPT, yo inmediatamente entregare dicho pago a RPT.

Yo entiendo y estoy de acuerdo que soy totalmente responsable por todos los gastos que incurra por los servicios profesionales recibidos y que pagare cualquier suma requerida de mi cuando sea solicitada. Yo entiendo y estoy de acuerdo que si es necesario comenzar una accion legal para colectar gastos pendientes en mi cuenta, yo sere responsable por cualquier gasto y/o costos de la corte, en adiccion al saldo pendiente.

Firma de la persona responsable de los cargos: _____ Fecha: _____
(Si el paciente es menor de 18 anos, los padres o guardian legal debe firmar)

Relacion con el paciente, **si el paciente es menor de 18 anos:** Madre Padre Guardian Legal

ASEGURANZA PRIMARIA

Nombre del Portador: _____ Fecha de Nacimiento: ____/____/____

Relacion con el Paciente: Yo Esposo/Esposa Padres Otro: _____

Domicilio del Portador: _____
(Si es diferente al paciente) Calle Ciudad Estado Codigo Postal

Numeros Telefonicos: (____) _____ - _____ (____) _____ - _____ Seguro Social: _____ - _____ - _____
(Si es diferente al paciente) Telefono de Casa Telefono Celular

Nombre de Aseguranza: _____ Telefono: (____) _____ - _____

Numero de Poliza: _____ Numero/Nombre de Grupo: _____

Empleo del Portador: _____ Telefono:(____) _____ - _____

ASEGURANZA SECUNDARIA **Si no tiene cobertura secundaria, inicie aqui ()

Nombre del Portador: _____ Fecha de Nacimiento: ____/____/____

Relacion con el Paciente: Yo Esposo/Esposa Padres Otro: _____

Domicilio del Portador: _____
(Si es diferente al paciente) Calle Ciudad Estado Codigo Postal

Numeros Telefonicos: (____) _____ - _____ (____) _____ - _____ Seguro Social: _____ - _____ - _____
(Si es diferente al paciente) Telefono de Casa Telefono Celular

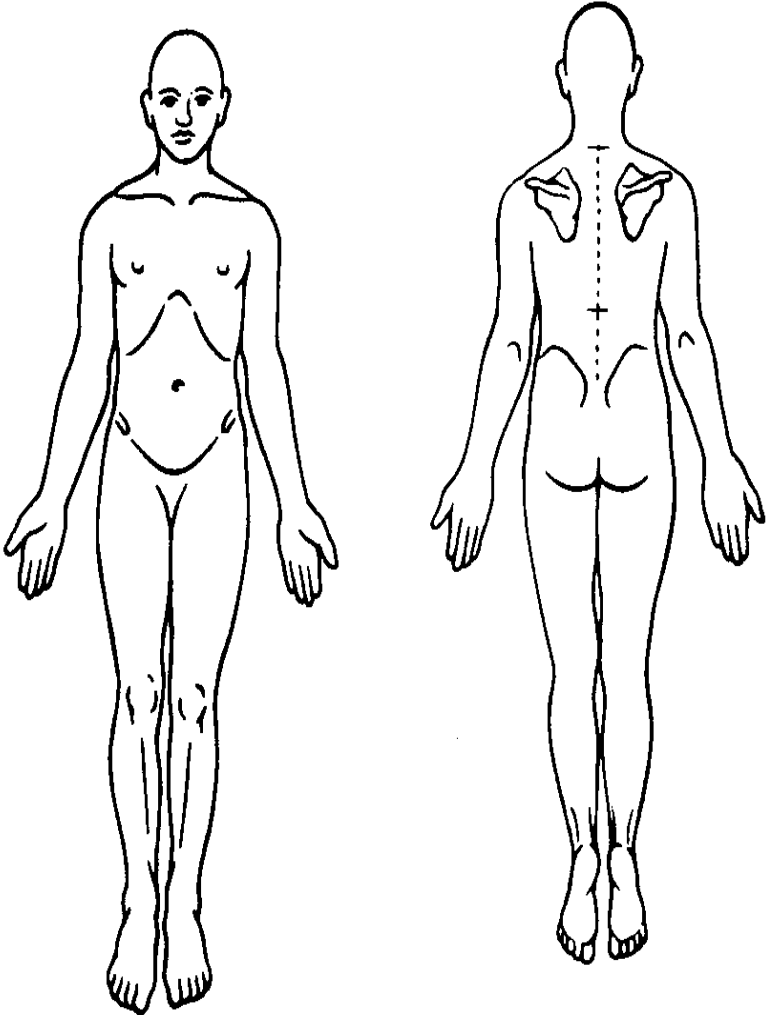
Nombre de Aseguranza: _____ Telefono: (____) _____ - _____

Numero de Poliza: _____ Numero/Nombre de Grupo: _____

Empleo del Portador: _____ Telefono:(____) _____ - _____

Rancho Physical Therapy

EVALUACION DEL DOLOR GRAFICO

INTENSIDAD DEL DOLOR	LOCALIZACION DEL DOLOR DIAGRAMAS DE CUERPO
10 El peor dolor que podria ser	
9 Insoportable	
8	
7 Grave	
6	
5 Moderado	
4	
3 Leve	
2 Ligero	
1	
0 No hay dolor	

1. Dibuje una linea en la escala de intensidad de dolor en el punto que mejor describa su dolor en el momento actual.
2. Dibuje la ubicacion de sus quejas de dolor en los diagramas de cuerpo ubicados en esta pagina.
3. Si usted tiene otros sintomas, como hormigueo or entumecimiento, dibuje estas como una linea de puntos.

Por favor, describa los detalles de su lesion, incluyendo la fecha de la lesion y cualquier tratamiento de las lesion: