RIVIERA SPORTS PHYSICAL THERAPY

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.

RIVIERA SPORTS PHYSICAL THERAPY'S LEGAL DUTY

RIVIERA SPORTS PHYSICAL THERAPY 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, RIVIERA SPORTS PHYSICAL THERAPY 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.

RIVIERA SPORTS PHYSICAL THERAPY may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, RIVIERA SPORTS PHYSICAL THERAPY's policy is to 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 further disclosures at any time.

RIVIERA SPORTS PHYSICAL THERAPY 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. RIVIERA SPORTS PHYSICAL THERAPY 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 RIVIERA SPORTS PHYSICAL THERAPY 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 U.S. Department of Health and Human Services. For further information on RIVIERA SPORTS PHYSICAL THERAPY's health information practices, or if you have a complaint, please contact the following person:

RIVIERA SPORTS PHYSICAL THERAPY
1204 S. PACIFIC COAST HWY
REDONDO BEACH, CA 90277

RIVIERA SPORTS PHYSICAL THERAPY

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Riviera Sports Physical Therapy's Notice of Information Practices. I understand that Riviera Sports Physical Therapy 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 and/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 Riviera Sports Physical Therapy 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 Riviera Sports Physical Therapy'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 Name

_____
Signature

_____
Signature of Parent/Guardian
(if patient is a minor)

_____
Date

RIVIERA SPORTS PHYSICAL THERAPY

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for RIVIERA SPORTS PHYSICAL THERAPY to furnish any medical care and treatment to myself which is considered necessary and proper in diagnosing or treating my physical and mental condition.

Patient/Parent/Guardian_____ Date_____

Benefit Assignment/Release of Information

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and third party payors to RIVIERA SPORTS PHYSICAL THERAPY in order to secure payment. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Parent/Guardian_____ Date_____

No Show/Cancellation Policy

I, the undersigned, do hereby agree to give RIVIERA SPORTS PHYSICAL THERAPY at least 24 hours advance notice should I need to cancel an appointment. In the event that notification is not made, I understand that my account will be automatically charged a $25.00 cancellation fee.
I, the undersigned, agree to arrive within 15 minutes of my appointment time and understand that arrival after the grace period will result in the cancellation of my appointment and a $25.00 fee.

Patient/Parent/Guardian_____ Date_____

Home Healthcare

If you have received Home Health Care in the last calendar year, please provide the date of discharge and a copy of the Discharge Slip.

Date of Discharge: _____

Release Consent of Medical Records Agreement Form

In general, the HIPAA privacy rule gives individuals the right to refuse a restriction on uses and disclosure of their protected health information. The individual is also provided the right to request confidential communications or that communication of protected health information be made by alternative means.

I hereby consent to the release of my protected health information which consists of but is not limited to medical/billing/personal information to the following individuals. I understand this authorization will be in effect until which time it is revoked by my request. I understand that Riviera Sports Physical Therapy, Inc. will not be held accountable for the information released to the following persons:

Name:	Relationship/Contact Information:
_____	_____
_____	_____
_____	_____

I wish to be contacted in the following manner: **(Please check all that apply)**

□ Home phone: _____
- □ Okay to leave detailed message regarding any medical/billing/personal info.
- □ Leave message with call back number only
- □ Okay to fax all/any information to home fax: _____

□ Cell number: _____
- □ Okay to leave detailed message regarding any medical/billing/personal info.
- □ Leave message with call back number only

□ Work number: _____
- □ Okay to leave detailed message regarding medical/billing/personal info.
- □ Leave message with call back number only
- □ Okay to fax all/any information to work fax: _____

□ Written Communication
- □ Okay to send mail to my home address
- □ Okay to send mail to my work/office address
- □ Okay to send e-mail to: _____

Patient/Parent/Guardian Signature:	Date:
_____	_____

RIVIERA SPORTS
PHYSICAL THERAPY

VAS (VISUAL ANALOG SCALE) PAIN SCALE

Patient Name:_____ **Date:**_____

Instructions: Please mark along the scale where you feel your pain/weakness level is *today*, at its *best*, and at its *worst*.

TODAY

|_____|

No Pain (0) Worst Pain Imaginable (10)

BEST (since the pain/weakness began)

|_____|

No Pain (0) Worst Pain Imaginable (10)

WORST (since the pain/weakness began)

|_____|

No Pain (0) Worst Pain Imaginable (10)

RIVIERA SPORTS
PHYSICAL THERAPY

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

EMPLOYMENT

Name (Last, First):	Date: ___/___/_____	☐ M ☐ F Age:

Job Description:	☐ Full Time ☐ Part Time ☐ Retired ☐ Student Grade:

PERSONAL HEALTH HISTORY

Have you been diagnosed with or do you currently have:

Chest pain	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Difficulty with bladder, bowel	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Dizziness, fainting	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Metal implants	☐ Yes	☐ No
Nausea, vomiting	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No
Night sweats, night pain	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Numbness in genital area	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Problems with vision, hearing, speech	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Unexplained weight change	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Cancer Type:	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No

SPORTS/REGULAR EXERCISE

Type	Frequency

PREVIOUS SURGERIES/HOSPITALIZATIONS

Year	Reason

RIVIERA SPORTS
PHYSICAL THERAPY

CURRENT MEDICATIONS

(Attach written list, if available)

Patient Name: _____ Date: ___ / ___ / _____

Allergies: _____

Primary Care Physician: _____

Medication (Brand and Generic Names)	Dosage and Frequency	Reason for Use