~~ATI PHYSICAL THERAPY~~

CLINIC NAME: CR & ST Mission Viejo

PATIENT INFORMATION

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ MOBILE ( ) _____ WORK PHONE ( ) _____ Ext____

DATE OF BIRTH _____ E-MAIL: _____ PATIENT GENDER: _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATIONSHIP _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

DATE OF INJURY OR SURGERY _____ DIAGNOSIS _____ ICD # _____

CAUSE OF COMPLAINT DUE TO: ☐ AUTO ☐ WORK ☐ OTHER _____

NAME OF INSURED/ POLICY HOLDER

NAME _____ RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY # _____

EMPLOYER NAME _____ PHONE _____

INSURANCE INFORMATION

Do you have an secondary insurance? ☐ Yes ☐ No

PRIMARY

NAME OF INSURANCE COMPANY _____ Auth / Rx Needed? ☐ Yes ☐ No

BILLING ADDRESS: _____

PHONE ( ) _____ - _____ REPRESENTATIVE _____

POLICY/ ID# _____ GROUP# _____ EFFECTIVE DATE: _____

BENEFITS _____% DEDUCTIBLE _____ MET _____ COPAY $_____ OUT OF POCKET MAX _____

REQUIRES PRE –AUTH: ☐ YES ☐ NO AUTH# _____ # OF VISITS AUTHORIZED _____

AUTHORIZED BY _____ DATE _____ PLAN LIMITATIONS: _____

SECONDARY

NAME OF INSURANCE COMPANY _____ PHONE # _____

INSURANCE BILLING ADDRESS: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY/ MEMBER ID# _____ GROUP# _____

WORKERS' COMPENSATION / AUTO INFORMATION

NAME OF INSURANCE COMPANY _____ PHONE # _____

ADDRESS TO SUBMIT CLAIMS _____

ADJUSTER _____ PHONE# _____ FAX# _____

DATE OF INJURY _____ CLAIM# _____ PREVIOUS PT/OT (This Injury) ☐ YES ☐ NO

EMPLOYER _____ PHONE# _____

AUTO PATIENTS ONLY: POLICY HOLDER: _____ RELATIONSHIP: _____

AUTO POLICY # _____ MED-PAY ON POLICY: ☐ YES ☐ NO AMOUNT $_____

MEDICARE PATIENTS ONLY

DO YOU HAVE MEDICARE PART A & PART B? ☐ YES ☐ NO

HAVE YOU RECEIVED HOME HEALTH WITHIN THE LAST 2 MONTHS? ☐ YES ☐ NO

ARE YOU CURRENTLY RECEIVING ANY TYPE OF THERAPY AT ANOTHER FACILITY OR HOSPITAL? ☐ YES ☐ NO

HAVE YOU PREVIOUSLY RECEIVED PT/OT FOR THIS DIAGNOSIS? ☐ YES ☐ NO

Insurance Benefits and Payment Policy: The information listed above is a description of your healthcare benefits, which was given to us by a representative of your health insurance company. It is not a guarantee or authorization of payment. Actual benefits cannot be determined until the claim has been received and processed by your insurance. We will call to verify your insurance coverage. Deductibles and co-payments are due at the time of service.

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorneys fees. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to the above name healthcare provider.

I consent to have this healthcare provider and/or its' affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

_____ _____

PATIENT'S SIGNATURE DATE

Rev : 7

.ehab & Sports Therapy- Mission Vi

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke? ☐ Yes ☐ No**

Sex: ☐ Male ☐ Female If female, are you currently pregnant? ☐ **No** ☐ **Yes If yes,** ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No ☐ Yes	Cancer	☐ No ☐ Yes	Arthritis	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Heart Condition	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Respiratory Problems	☐ No ☐ Yes

Other: _____

Who referred you to physical therapy? _____

Primary Physician _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): _____

Recent flare-up? ☐ No ☐ Yes If yes, when _____

What activities are limited by this condition? (e.g. lift, reach): _____

How did your injury/symptoms occur? _____

_____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better? ☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? _____

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind? _____

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

☐ Physical therapy If yes, when? ___/___/___to ___/___/___

What was done? _____

☐ Chiropractor If yes, when? ___/___/___to ___/___/___

What was done? _____

☐ Medications: _____

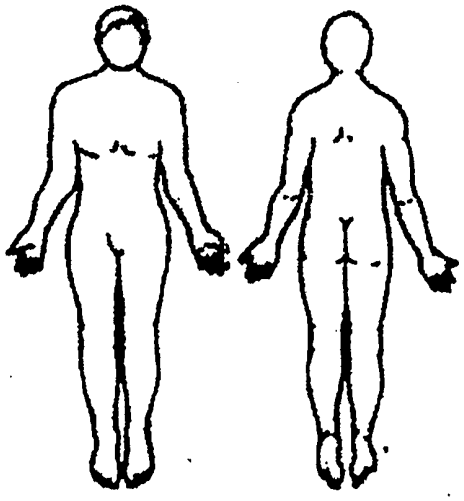
☐ X-ray _____ ☐ MRI _____

☐ CT scan _____ ☐ Other: _____

☐ Exercises: What kind? _____

Indicate on body diagrams where your symptoms are located

■ = Pain *III* = Numbness



Have you fallen 1 or more times in the past year for any reason? YES ☐ NO ☐

Do you have any numbness or abnormal sensation in your feet or hands? YES ☐ NO ☐

Do you have special or modified footwear or shoe inserts to prevent ulcers? YES ☐ NO ☐

Cal Rehab & Sports Therapy
26302 La Paz Road #105, Mission Viejo, CA 92691
Phone: 949.206.1700 / Fax: 949.206.1800

PATIENT NAME (Please print): _____ **DATE:** _____

3.5.1C PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

Initial: _____ I have read and understand the HIPAA Protected Health Information Privacy Notice 3.5.1A. I understand that upon request a copy of the complete notice will be provided to me.

FINANCIAL AGREEMENT

Initial: _____ I authorize and give consent to California Rehabilitation and Sports Therapy (C.R.S.T.) to administer any Physical/Occupational Therapy treatment. I understand that I will be responsible for all charges and fees to the clinic while patient being treated.

INSURANCE VERIFICATION AND BILLING

Initial: _____ Cal Rehab will verify eligibility and benefits for physical therapy and bill your insurance company for services as a courtesy. However, the patient is ultimately responsible for prompt and full payment for all services provided.

CANCELLATION POLICY AND ATTENDANCE

Initial: _____ **It is extremely important you arrive on time for your appointment.** Being late may result in your appointment being rescheduled due to lack time for a productive treatment.

Initial: _____ We request you provide twenty-four (24) hours notice for cancellations. **Less than 24 hours notice and "no-shows" will be subject to a $50 cancellation fee, due at the next visit.** Medical insurance companies will not cover any cancellation fees. Payment is the responsibility of the patient.

I have read the above policies and procedures and understand my responsibilities.

Patient Signature: _____ Date: _____

Reviewed with patient by _____ Date: _____
(Cal Rehab Employee)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, California Rehabilitation and Sports Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among California Rehabilitation and Sports Therapy personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for California Rehabilitation and Sports Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that California Rehabilitation and Sports Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand California Rehabilitation and Sports Physical Therapy for **Worker's Compensation Cases**, will release the minimum necessary PHI/ePHI to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that California Rehabilitation and Sports Therapy is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_____] Spouse/Children:_____

[_____] Other: _____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of California Rehabilitation and Sports Therapy and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative Date Relationship to Patient

_____

Printed name of patient