

**SCOR**  
*San Clemente Orthopaedic Rehabilitation*



**Rancho Santa Margarita**  
*Physical Therapy and Sports Medicine*

**PATIENT INFORMATION & BRIEF HISTORY**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Referred to this office by Doctor \_\_\_\_\_

Date of Injury \_\_\_\_\_ Date of Surgery \_\_\_\_\_

How did this injury occur? \_\_\_\_\_

Have you had previous physical therapy for your present condition for which you are to receive treatment here? Yes  No

If yes, state where: \_\_\_\_\_ When? \_\_\_\_\_

Do you now have or had any of the following:

- |                     |  |                         |  |
|---------------------|--|-------------------------|--|
| Diabetes            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sensitive to Heat / Ice | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | Pregnant                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Disease       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other Allergies         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Attack        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Previous Surgery        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Pacemaker           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hernia (any)            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Headaches           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Seizures                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Kidney Problems     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Metal Implants          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Nervous Disorders   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Cancer                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If yes to any of the above, please explain and give approximate dates: \_\_\_\_\_

Are you presently taking medications? Yes  No  If yes, please list what medications and for what condition: \_\_\_\_\_

The above information is correct to the best of my knowledge.

I hereby authorize Rancho Santa Margarita Physical Therapy and Sports Medicine (RSMPT) with full information regarding treatment rendered, when so requested.

I hereby authorize my insurance company to pay directly to Rancho Santa Margarita Physical Therapy and Sports Therapy (RSMPT) medical benefits otherwise payable to me, and I will be responsible to RSMPT for all expenses incidental to treatment rendered not paid under this plan.

I hereby render my consent for evaluation and treatment of my injury/illness to RSMPT.

Patient Signature \_\_\_\_\_ (or if Minor, Parent/Guardian Signature)

Parent/Guardian Name \_\_\_\_\_

David L. Valentine, PT, SCS

Craig A. Legacy, PT, ATC, CSCS

Daniel A. Souza, PT

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## **ELECTRICAL STIMULATION/IONTOPHORESIS PADS**

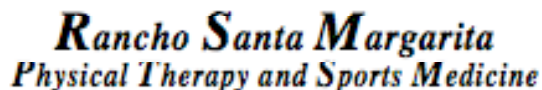
Dear Clients:

Due to insurance companies not providing reimbursement for individual patient electrodes for electrical stimulation and/or iontophoresis, we regret that we must charge our patients directly so that we may cover our costs. This ensures that you will have personalized, clean electrodes for your individual use. Each packet for electrical stimulation lasts approximately 15 visits and a new packet will be issued when necessary. A new packet is required for every use of iontophoresis. The fee is \$20 for electrical stimulation/iontophoresis pads.

I understand and agree to the above terms.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



### Payment Schedule

This payment schedule is acceptable after your deductible has been met and an assignment of benefits has been signed. If the yearly deductible has not been met, different arrangements must be made.

There will be an initial charge of \$130.00 for the evaluation and \$90.00 for each subsequent treatment. Additional charges may be incurred depending on treatment provided. This will be billed to your insurance company or to the patient if it is a "self-pay" account.

The co-payment is due at the same time of service.

Any supplies including pillows, tubing, braces, supports, etc. are to be paid when items are received. We will bill insurance if we have the proper prescription for the supplies. If insurance pays, we will reimburse the patient.

Any payment you may receive from the insurance company should be sent to this office to be applied to your account. Any credit balance will be refunded at the conclusion of your therapy.

- **Work Injury:** Injured in the course of employment. Worker's compensation information is needed, date of injury, employer's name, address, telephone number, and doctor's prescription.
- **Medicare Patient:** Medicare does not approve or pay for all the charges incurred for physical therapy. All charges not covered by Medicare and/or secondary insurances are the responsibility of the patient.
- **Auto Accident/Bodily Injury:** The proper insurance will be billed directly, after the assignment of benefits is signed. No 3<sup>rd</sup> party billing will be accepted.

AS A COURTESY, INSURANCE BENEFITS WILL BE VERIFIED FOR OUT PATIENT PHYSICAL THERAPY, BUT THIS IS NOT A GUARANTEE OF PAYMENT. IT IS THE RESPONSIBILITY OF THE PATIENT TO KNOW WHAT THEIR INSURANCE WILL COVER FOR PHYSICAL THERAPY.

Patients who do not cancel appointments 24 hours prior to their scheduled appointment will be charged a \$40.00 No Show Fee. \*\*\*\*\*I have read and acknowledge said cancellation policy (initial here) \_\_\_\_\_

I understand and agree that I am responsible for all charges regardless of my existing medical coverage. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any and all legal fees and court costs, in addition to the outstanding balance.

If you have any questions regarding your account or your insurance, please contact our medical management office at 888-686-3626 between 8:00 a.m. and 5:00 p.m. We believe that a clear definition of our financial policy will allow us to concentrate on the more important issue---**regaining and maintaining your health.**

I UNDERSTAND AND AGREE TO THE ABOVE TERMS AND RESPONSIBILITIES.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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## **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

### **SCOR/RSMPT'S LEGAL DUTY**

SCOR/RSMPT 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**

SCOR/RSMPT 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, SCOR/RSMPT 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. SCOR/RSMPT 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, SCOR/RSMPT'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 future disclosures at any time.

SCOR/RSMPT 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 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. SCOR/RSMPT 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 SCOR/RSMPT 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 at the top of this page. You may also send a written complaint to the US Department of Health and Human Services. For further information on SCOR/RSMPT's health information practices or if you have a complaint, please contact us at the address listed above.

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**SCOR/RSM  
PATIENT INFORMATION CONSENT FORM**

I have read and fully understand SCOR/RSM’s Notice of Information Practices. I understand that SCOR/RSM may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provide 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 SCOR/RSM 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 SCOR/RSM’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

\_\_\_\_\_  
Date

I also authorize SCOR/RSM to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand that I have the right to copy or inspect any information used for these purposes. I also understand that this authorization does not affect my consent to use my protected health information for treatment, billing or operations related to treatment and billing.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date