Rehab Alliance

WELCOME TO REHAB ALLIANCE THERAPY AND FITNESS CENTER

We are pleased that you have selected this facility for your therapy needs and will make every effort to provide you professional therapeutic services.

In order to do so, we ask that you observe the following department policies:

1. If you have a PPO Plan, at your first appointment, ***please bring your signed physician prescription*** if available and any pertinent information (MRI/XRAY Reports etc) and completed intake paperwork. If you have an HMO Plan through Memorial Care, Regal Medical Group, or Healthcare Partners/Talbert Medical Group, ***you do not need to bring a physician prescription***, an authorization has been sent to our office prior scheduling.

2. You will be given a specific schedule to best fit your needs. If you are unable to keep an appointment, please call and cancel at ***(949) 707-5555***. If you do not show for a scheduled appointment and have not called to cancel, another patient may fill your appointment time. If you wish to resume treatment, you will need to reschedule.

3. Please be on time for your appointment. If you arrive late, we cannot guarantee that all of your treatment can be provided. This will be at the discretion of the therapist, as their schedule allows.

Thank you for abiding by these policies. If you have questions or concerns, please do not hesitate to discuss them with your therapist.

Thank you,

Victoria Hayes
President of Rehab Alliance

I have read and understand the policies of Rehab Alliance Therapy and Fitness Center.
Date:_____ Signature:_____

Rehab Alliance Therapy* and *Fitness Center

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.

REHAB ALLIANCE'S LEGAL DUTY

Effective April 14, 2003, Rehab Alliance 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. Rehab Alliance is also required by law to have appropriate technical and administrative safeguards in place to protect your information.

USES AND DISCLOSURES OF HEALTH INFORMATION

Rehab Alliance 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, Rehab Alliance 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.

Rehab Alliance 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, Rehab Alliance'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.

Rehab Alliance 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. Rehab Alliance 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 Rehab Alliance 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 US Department of Health and Human Services Office for Civil Rights, the federal agency charged with enforcing the federal health privacy law. For further information on Rehab Alliance's health information practices or if you have a complaint, please contact the following person:

***Attn: David Hayes: 22995 Mill Creek Drive Suite A, Laguna Hills, CA 92653,* (949) 707-5555**

Rehab Alliance Therapy & Fitness Center
Client intake form
***Bolded items MUST be completed prior to being seen by therapist.**

SECTION I PATIENT AND INSURANCE INFORMATION

Evaluation Date: _____ Date of Injury: _____

Ins Type (*Circle one*): Medicare, Memorial Care, Regal, Healthcare Partners/Talbert, PPO, Worker's Comp , Cash

Last name: _____ First: _____ MI: _____

Address: _____ City: _____ State _____ Zip: _____

Home phone # ( ) _____ Work phone/cell phone # ( ) _____

Email Address:_____

Date of Birth: ____/____/_____ Sex: M F Marital Status: _____

Referring physician: _____ Physician phone # ( ) _____

Physician address: _____ City: _____ State: ____ Zip: _____

Physician specialty (e.g. Orthopedics): _____ Date last seen by physician: _____

Emergency contact: (Other than living with you) _____ Phone: ( ) _____

Address: _____ City: _____ St. _____ Zip: _____

Primary Insurance Information

Name of primary insured _____

Employer name: _____ Address: _____

Occupation: _____

Policy holder date of birth: _____ Relationship to insured: _____

Copy of Insurance Card attached: Yes___ Skip below No ____Complete below

Policy # _____ Group # _____ Plan # _____

Insurance company name: _____ Phone # ( ) _____

Address: _____ City: _____ State:_____ Zip code: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to insured: _____

Policy # _____ Group # _____ Plan #_____

Insurance company name: _____ Phone # ( ) _____

Address: _____ City: _____ State: _____Zip code: _____

Workers' Compensation or Auto Insurance Information

Date of injury/accident: _____

Employer's name (W/C only) at time of injury: _____

Claim # _____ Adjustor's/Agent's name: _____

Insurance company name: _____ Phone # ( ) _____

Address: _____ City: _____ State: _____ Zip code: _____

SECTION II Authorizations

A. Consent for Treatment and Release of Pertinent Medical Information

I authorize Rehab Alliance Therapy & Fitness Center to administer therapy services to me. I also authorize my physician(s), hospital(s), attorney or other medical entity to release any of my medical record information to support my therapy treatment, to Rehab Alliance Therapy and Fitness Center.

B. Authorization to pay Rehab Alliance Therapy & Fitness Center/Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to Rehab Alliance Therapy & Fitness Center and I am financially responsible for the non-covered services, deductibles and co-payments. I also authorize Rehab Alliance Therapy & Fitness Center to release any information to process this claim.

C. Patient Information and Consent for Privacy Practices

I have received and read the Rehab Alliance Therapy & Fitness Center's Notice of Information Practices. I understand that Rehab Alliance Therapy & Fitness Center may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided 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 Rehab Alliance Therapy & Fitness Center will consider requests for restriction on a case by case basis but does not have to agree in writing to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Rehab Alliance Therapy & Fitness Center'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

_____ _____

Patient Signature (or Guardian) **Date**

Rehab Alliance Therapy & Fitness Center
Client Intake Form

SECTION III MEDICAL CONDITIONS

Check if you have or had any of the following conditions:

- ❑ Asthma
- ❑ Arthritis
- ❑ Blood Transfusions
- ❑ Bowel/Bladder Issues
- ❑ Fractures
- ❑ Hepatitis
- ❑ Shingles
- ❑ High Cholesterol
- ❑ Hypoglycemia
- ❑ Depression
- ❑ Liver problems:_____
- ❑ Polio
- ❑ Thyroid problems:_____
- ❑ Allergies
- ❑ Cancer
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Stroke
- ❑ Kidney Problems:_____
- ❑ Osteoporosis
- ❑ Headaches
- ❑ Dizziness
- ❑ Seizures
- ❑ Hernia
- ❑ Recent falls
- ❑ Other: _____

Height: _____Weight:_____

Have you **recently** experienced: Check those that apply

____ Unexplained weight loss/gain ____ Nausea/vomiting ____ Fever/Chills/Sweats
____ Excessive fatigue ____ Excessive weakness ____ Numbness or Tingling

Do you have any metal implants (joint replacements, plates, rods, screws, stents, etc.)? ____ yes ____ no
Are you currently or have you taken steroid medications? ____ yes ____ no
Are you currently taking anti-coagulant medications (e.g. Coumadin)? ____ yes ____no
Do you have a pacemaker or IAD (internal automated defibrillator)? ____yes ____no
For Women: Are you pregnant? ____ yes ____no

Previous Surgeries/Date: _____
_____
Previous Injuries/Date: _____
_____
Please check any diagnostic tests done for this condition.

- ❑ X-ray Results _____
- ❑ MRI Results _____
- ❑ CT Results _____
- ❑ EMG (nerve test) Results _____
- ❑ Other _____

List **any** medications you are currently taking _____
_____

Patient Signature (or Guardian) _____ Date _____

Rehab Alliance **Therapy & Fitness Center**
22995 Mill Creek Drive **Rehab With *Our* Personal Touch**
Laguna Hills, CA 92653-1215
(949) 707-5555 FAX (949) 707-5706

Patient Name:

DOB:

Rehab Alliance Therapy & Fitness Center
Client Intake Form

SECTION IV INFORMATION ON PRESENT CONDITION

Employment Status (Please Circle): Full Duty, Modified Duty, Retired, Unemployed, Disability

How and when did the symptoms begin? _____

Is this from a recent automobile accident? Y / N If yes, what was the date_____

Are your symptoms? (Please Circle): Improving, Worsening, Unchanging

Is this due to a traumatic event/injury? _____

Where is the location of your pain? _____

Are there any radiating symptoms? _____

Do you have any numbness/tingling? _____

Is there a pattern to your pain during the day (e.g. worse in the morning or evening)? _____

Is your sleep disturbed? _____

Is there any history of previous injury to the same area? _____

Have you ever had previous treatment for this condition? _____

What goals do you have for physical therapy? _____

Please check the following activities **that make your symptoms better or worse**:

Better	Worse		Better	Worse	
		Rest/Sleep			Meal preparation
		Lying on your back			Eating
		Lying on your side Left Right			Coughing/Sneezing
		Lying on your stomach			Yawning
		Rolling Over			Housework
		Sitting Time _____ minutes			Vacuuming
		Rising from sitting			Yardwork
		Standing Time _____ minutes			Deskwork/Computer/Mouse
		Walking Distance _____			Childcare List limitations:
		Change in position			
		Reaching forward			
		Reaching behind			Driving
		Reaching overhead			Getting in and out of car
		Lifting weight _____ pounds			Sports/Recreation
		Dressing			Stairs
		Grooming			Medication
		Bending			
		Squatting			Other Specify:

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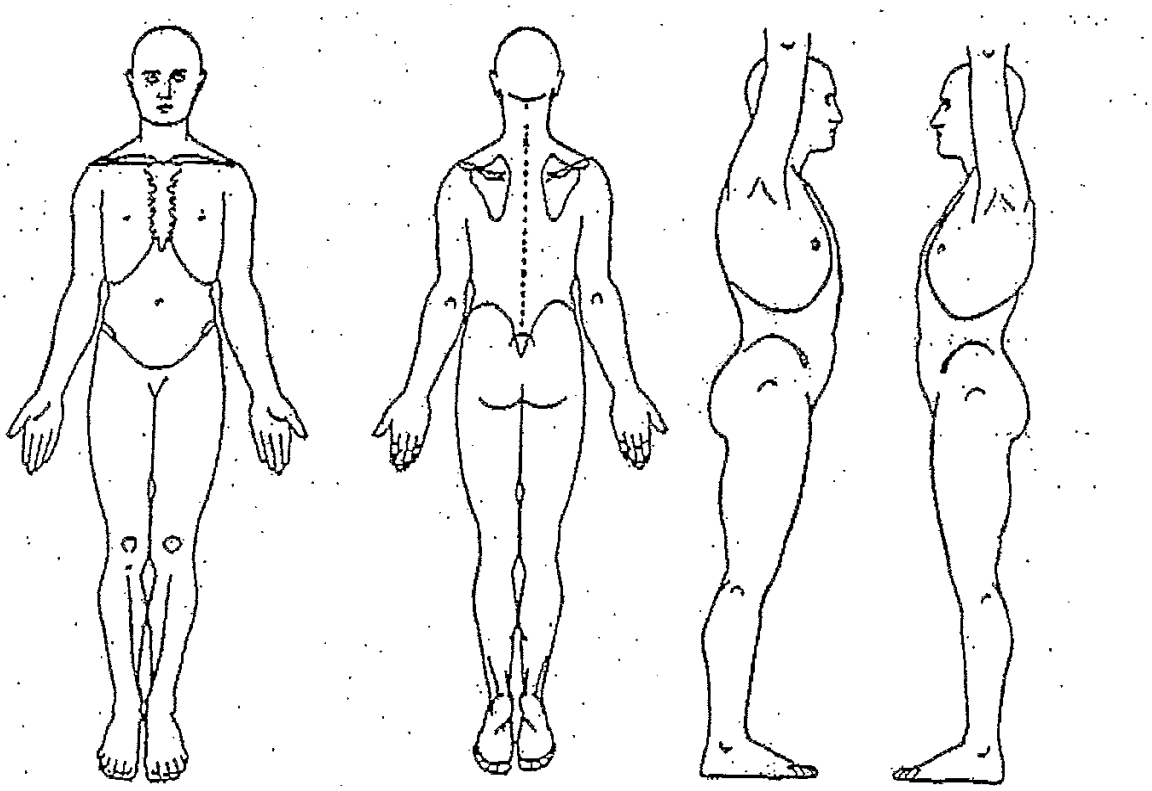
SECTION VII	PAIN AND SENSATION ASSESSMENT

Mark the location of your symptoms on the figures below with an X. Mark and label with a 0 any areas where you experience Tingling, Numbness or Burning.



On the **PAIN INTENSITY** scale below, circle the level of your primary pain where level 1 is slightly uncomfortable and level 10 is unbearable.

(LEAST PAIN) 1 2 3 4 5 6 7 8 9 10 (MOST PAIN)

What type of symptoms do you experience? o Sharp o Dull Ache o Radiation/ Shooting

How frequent are your symptoms? o Constant o Comes & Goes

Are your symptoms worse in the: o AM o PM?

Does your pain disturb your sleep? o YES o NO

Patient Signature (or Guardian):_____Date: _____

DIRECTIONS

+--

From South Orange County
- Take the 5 Freeway NORTH
- Exit Lake Forest Drive and turn LEFT
- Pass Moulton Parkway
- Next light Mill Creek Drive/Scientific Way Turn Left
- Second driveway on RIGHT
- Building immediately on RIGHT

From North Orange County
- Take the 5 Freeway SOUTH
- Exit Lake Forest Drive and turn RIGHT
- Pass Moulton Parkway
- Next light Mill Creek Drive/Scientific Way Turn Left
- Second driveway on RIGHT
- Building immediately on RIGHT

From Local Surface Streets
- Take Moulton Parkway NORTH
- Turn LEFT on Lake Forest Drive
- Next light Mill Creek Drive/Scientific Way Turn Left
- Second driveway on RIGHT

22995 Mill Creek Drive

Suite A

Laguna Hills, CA 92653

(949) 707-5555