MEDICARE INTAKE SHEET

Referring physician:		Today's date: / /
Patient name:	DOB: / /	Age:
Address:		
Phone #: ( )	Social Security #:	Gender: M / F
Driver License #:		
Email Address:		

PRIMARY INSURANCE INFORMATION

Insurance name: Medicare	
Insurance address:	
Policy #:	Name on Policy:
Policy holder's address:	
Policy holder's social security #:	Relationship to patient:

EMERGENCY NOTIFICATION

Name:
Phone #: ( )
Relationship:

MEDICAL HISTORY

Have you or any of your immediate family members ever been told you have:

Me	Family member		Me	Family member		Me	Family member	
☐	☐	Heart	☐	☐	Pacemaker/defibrillator	☐	☐	Smoking
☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐	Leg/ankle swelling
☐	☐	Lung	☐	☐	Gastro-intestinal	☐	☐	Currently pregnant
☐	☐	Anemia	☐	☐	Metal implants	☐	☐	Bladder
☐	☐	Kidney	☐	☐	Cancer	☐	☐	Osteoporosis
☐	☐	Seizures	☐	☐	Infection (last few weeks)	☐	Other:	______________

Please list any medication that you are currently taking or have recently used for any of the above medical conditions. ____

____

Have you had any hospitalization? ____

Please list any known allergies: ____

____

HISTORY OF CURRENT INJURY

When and how did the injury occur? ____

____

____

Have you received any previous treatment for this injury? ______________________

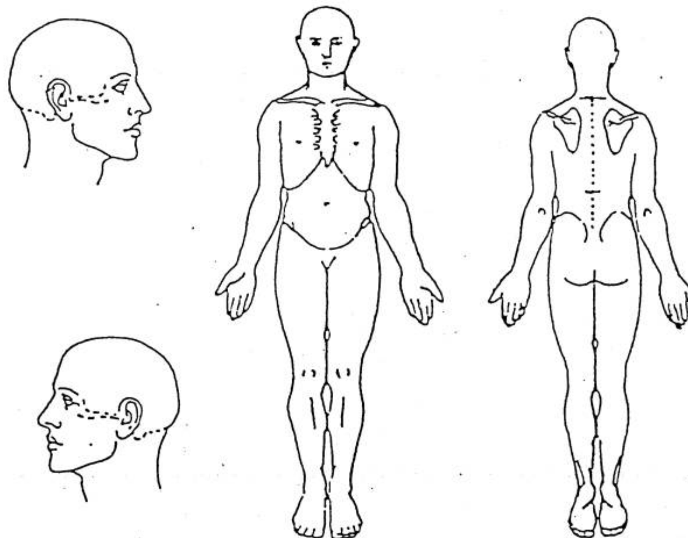
____

Are you taking pain medications? Please list them: __________________________

Please place a checkmark next to any of the following symptoms:

☐ Fever	☐ Sweats	☐ Shortness of breath	☐ Diarrhea
☐ Skin rash	☐ Problems with vision	☐ Cough	☐ Constipation
☐ Weakness	☐ Dizziness	☐ Hoarseness	☐ Change in bowel/bladder
☐ Tingling	☐ Nausea/vomiting	☐ Difficulty swallowing	☐ Involuntary weight loss/gain
☐ Numbness	☐ Heart palpitations	☐ Painful swallowing	☐ Bleeding of any kind
☐ Joint pain	☐ Difficulty breathing	☐ Other: ______________________	

Please indicate the location of your pain on the picture below:



http://www.continuingedcourses.net/active/courses/images/course016-body.jpg

On the scale below, circle your worse pain level:

(pain free) 0 1 2 3 4 5 6 7 8 9 10 (worse possible pain)

Please circle all that apply to describe your pain: sharp, stabbing, throbbing, aching, shooting, burning, tingling, heaviness, discomfort, dull, intermittent, constant

If constant, do you have the pain right now? Y / N

Are the symptoms getting: ☐worse ☐better ☐staying the same

Aggravating factors: ____

Relieving factors: ____

Have you had this problem before? Y / N

Please give the name and dates of the surgeries you have had as a result of your injury: ______

____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ____________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Southern California Sports Rehabilitation

Patient/Provider Arbitration Agreement

1. Agreement to Arbitrate. The undersigned agree that, except as provided in this agreement, any dispute arising by and between Patient (as identified below) and Southern California Sports Rehab ("Provider") will be decided and resolved through arbitration by the Orange County, California, offices of J.A.M.S/Endispute's or its successor, and not by lawsuit or resort to court process except California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are knowingly giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Except as provided otherwise herein or as may be applicable to California law as it relates to arbitrations involving health care providers, all arbitrations shall be conducted in accordance with the provisions of JAMS/Endispute's Streamlined Arbitration Rules and Procedures in effect at share of the expenses and fees of the arbitration. The parties hereto agree that the arbitrator may not award punitive damages. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper party in a court action and upon such intervention and joinder any existing court action by, against or otherwise involving such additional person or entity shall be stayed pending arbitration. The parties hereto agree that provisions of California law applicable to health care providers shall apply to disputes with this arbitration agreement including but not limited to, Code of Civil Procedure sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitration a Discovery shall be conducted pursuant to Code of Civil Procedure Section 1238.5; however, depositions may be taken without prior approval of the neutral arbitrator. A Claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

In lieu of arbitration, Provider, at Provider's sole discretion, may file one or more actions in the Superior Courts (or Small Claims Court for matters within that Courts' jurisdiction) for the County of Orange, State of California to collect any fees owing the Patient to Provider. Such filings shall not waive Providers right to compel arbitration of any other claim.

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2. ***Miscellaneous.*** If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. By my signature below, I acknowledge receipt of a copy of this agreement. The parties hereto intend that this agreement binds all parties, their spouses, heirs and successors in interests. This agreement is governed by California Law.

BY SIGNING THIS AGREEMENT I UNDERSTAND THAT I AM VOLUNTARILY AGREEING TO HAVE ANY MALPRACTICE AND OTHER DISPUTES DECIDED THROUGH ARBITRATION AND THAT I AM GIVING UP MY RIGHT TO A JURY OR COURT TRIAL, THAT I HAVE NOT RELIED ON ANY ORAL REPRESENTATIONS RELATIVE TO ARBITRATIONS THAT ARE NOT IN WRITING AND INCLUDED IN THIS AGREEMENT, AND, FURTHER, I ACKNOWLEDGE RECEIPT OF A COPY OF THIS AGREEMENT.

Provider: Southern California Sports Rehabilitation:	**Patient:**	**Parent/Guardian** (if pt is a minor)
______________________ Signature Date	______________________ Signature: Date	______________________ Signature Date
______________________ Printed name and title	______________________ Printed Name	______________________ Printed Name

REQUEST FOR RELEASE
OF
MEDICAL RECORDS

To:____

Physician's Name

Address:_________________________City:_________________State:_____Zip Code:__________

I hereby request that my medical records
Be released to:

____

Physicians' Name

Address:_________________________City:_________________State:_____Zip Code:__________

Date:_____________________________

Patient's Signature:____________________________________

Print Name of Patient:____________________________________

Date of Birth:____________________Social Securtiy Number:______________________________

Treatment authorization: I authorize the treatment by Southern California Sports Rehabilitation.
I have read, understand, and agree to all information presented to me today.

____ ____________________________

Signature of Patient/Guardian Date

OF-011 Rev. 10/03

Southern California Sports Rehabilitation

PATIENT FINANCIAL RESPONSIBILITY WAIVER

I understand, acknowledge and agree that I am financially responsible for my deductible, co-insurance and any amount exceeding what my insurance company pays except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier my have regarding referrals, prior approvals, pre-authorizations and second opinions.

I have read the above waiver, authorization and acknowledgement and/or it has been fully explained to me, and I certify that I understand its contents and that I am competent to execute it or that I am authorized to execute it on the patient's behalf.

____________________________ _______________________

Patient Name Date

____

Patient Signature *(If legal representative, provide relationship to patient)*

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Witness Signature