Southern California Sports Rehabilitation

PRIVATE INSURANCE INTAKE SHEET

Referring physician:		Today's date: / /
Patient name:		DOB: / / Age:
Address:		
Phone #: ( )	Social Security #:	Gender: M / F
Driver License #:		
Employer:		
Employer's address:		
What is your occupation?		Are you presently employed? Y /

PRIMARY INSURANCE INFORMATION

Insurance Name:	
Insurance Address:	
Policy #:	Name on Policy:

EMERGENCY NOTIFICATION

Name:
Phone #: ( )
Relationship:

MEDICAL HISTORY

Have you or any of your immediate family members ever been told by your medical doctor that 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? _____

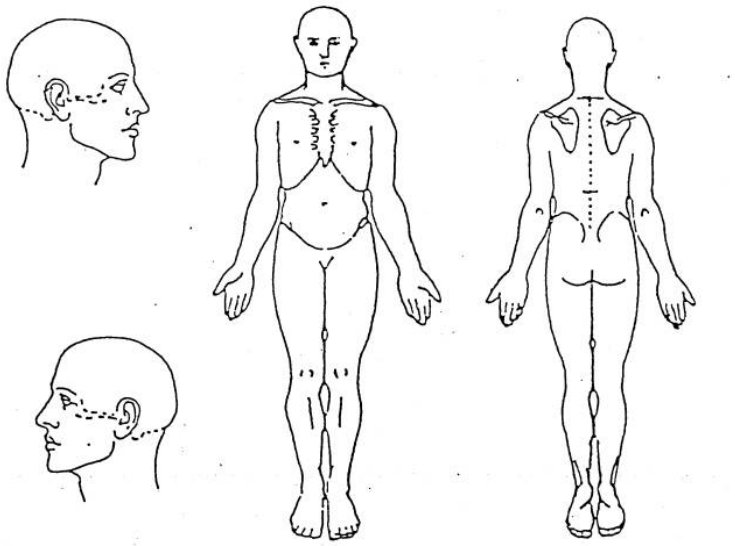
_____

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 today:

(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: _____

_____

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

Southern California Sports Rehabilitation

General Release Form

(This form is to be utilized by all aquatic therapy patients.)

In consideration for the pool owner's (the "Owner") grant of the use of the aquatic facilities (the "Premises") for aquatic/physical therapy, and SOUTHERN CALIFORNIA SPORTS REHABILITATION, LLC's (the "Company") making aquatic/physical therapy services ("Physical Therapy") available to the undersigned (the "Patient"), Patient, jointly and severally, hereby releases Owner, Company, and their respective employees (whether or not such employees are leased), members, shareholders, partners, owners, directors, tenants, lessors, employers and agents and their successors and assigns (collectively, the "Indemnified Persons") from all liability for injuries or damages of any nature that Patient may sustain as a result of his or her participation in the Physical Therapy or while in, at or about the Premises.

Patient hereby expressly waives and relinquishes all rights and benefits under California Civil Code section 1542 which reads in substantial part: *A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if know by him must have materially affected his settlement with the debtor.*

Patient agrees to indemnify and hold harmless the Indemnified Persons from all claims and demands whatsoever, which may be made in respect to injuries or damages of any nature sustained by Patient, in, at or about the Premises. Patient covenants not to sue Owner, the Company or any Indemnified Persons for any injuries as a result of his participation in the Physical Therapy or while in, at or about the Premises.

Patient is allowed in the pool only during the scheduled appointment, while a licensed physical therapist or a physical therapist assistant is present. If the patient enters the pool at any other time, it is at the patient's own risk. Patient shall comply with the rules and regulations pertaining to participation in the aquatic physical therapy, including but not limited to rules set by the owners of the pool and facilities.

If any term of this instrument is void, invalid or unenforceable for any reason, such term or provision shall be severed from this instrument and the remaining terms and provisions shall remain in force and effect.

I read and fully understand the terms of this release and acknowledge that this release is binding upon Patient, and his or her successors, assigns and estate.

Patient: _____ _____

Signature Date

_____ _____

Printed Name Date of Birth

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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)*

_____

Witness Signature