Southern California Sports Rehabilitation

WORKERS' COMPENSATION INTAKE SHEET

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

EMPLOYER INFORMATION

Employer (where injury occurred):	Date of injury: / /
Employer's address:	
What is your occupation?	Are you presently employed? Y / N

ATTORNEY INFORMATION

Attorney's name:	Phone #: ( )
Attorney's address:	

WORKERS' COMPENSATION INSURANCE

Workers' Comp. Insurance Name:		
Claim #:	Adjuster:	Phone #: ( )

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. _____

_____

_____

Please list any known allergies: _____

_____

HISTORY OF CURRENT INJURY

How did the injury occur? _____

_____

_____

Where have you received any previous treatment for this injury? _____

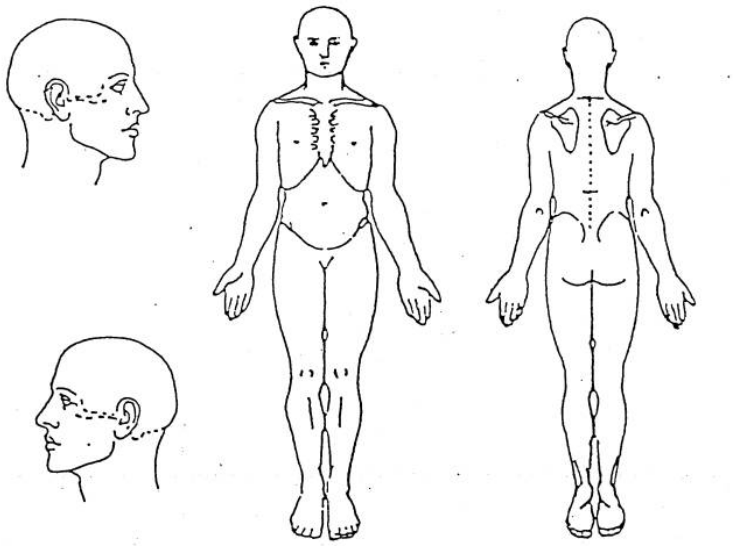
Number of visits and body parts treated: _____

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 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 the injury? Y / N

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

_____

Dear Patient,

To assure that you do not lose your disability benefits, you must ATTEND all prescribed physical therapy visits that your doctor requested. Your referring physician has asked that you make up any missed appointments or treatments that you missed. Your attorney will be notified if you fail to comply.

This memo is also to inform you that **we will bill your insurance carrier $50.00 if you do not show up or call to cancel** (NO SHOW/NO CALL) your scheduled appointment. We need at least a 24-hour notice of your cancellation so that we can schedule someone else in your time slot. We understand that emergencies do happen and we will deal with those on a one-to-one basis. Showing up to your scheduled therapy appointments is an extremely important matter in your rehabilitation.

Thank you for your cooperation and understanding,

Southern California Sports Rehabilitation Staff

Please sign to confirm that you understand this notice:

_____ _____

Patient Signature Date

_____

Patient Name

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

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

Southern California Sports Rehabilitation

Phone: (949) 975-1900 | Fax: (949) 975-0070
1809 E. Dyer Rd. # 313, Santa Ana, CA 92705

California's worker's compensation system will use a NEW process called INDEPENDENT MEDICAL REVIEW (IMR) to resolve disputes about medical treatment. All authorization requests for physical therapy will be sent to your insurance company for authorization. If the insurance company (Utilization Review) denies, delays or modifies a treatment request because the treatment is not medically necessary, the injury worker (patient) can ask for a review of that decisión, which is called an IMR (Independent Medical Review).

In order for this process to be successful and for you to get the medical treatment you deserve you must be involved and play an active role in this process.

If your case is accepted but your medical treatment is being denied the insurance company must do the following:

1. Send the injured worker a copy of the Utilization Review decisión letter
2. Send a completed copy of the IMR application

Once you receive these documents you only have **30 days** to sign and return all of the documents to your insurance company. You must do the following immediately upon receiving this notice from your insurance:

1. Sign the bottom of the IMR form requesting a review of the decisión to deny your treatment.
2. Mail the signed IMR form and a copy of the denial letter from the insurance company to:
   DWC-IMR
   c/o Maximus Federal Services, Inc.
   P.O. Box 138009
   Sacramento, CA 95813-8009

I understand my responsiblity in this process and I will sign and return the form with a copy of the denial letter upon receipt.

I understand that if I do not request this process I will not be able to receive the medical treatment requested.

Print Name: _____ Signature: _____ Date: _____

Southern California Sports Rehabilitation

Phone: (949) 975-1900 | Fax: (949) 975-0070
1809 E. Dyer Rd. # 313, Santa Ana, CA 92705

El sistema de la compensación del trabajador de California usará un NUEVO proceso llamado INDEPENDENT MEDICAL REVIEW (IMR) para resolver disputas sobre el tratamiento médico. Todas las peticiones de la autorización de la terapia física se enviarán a su compañía de seguros para la autorización. Si la compañía de seguros (Utilization Review) niega, retrasa o modifica una solicitud de tratamiento porque el tratamiento no es médicamente necesario, el trabajador (paciente) puede pedir una revisión de esto decisión, que se llama un IMR (Independent Medical Review).

Para que este proceso sea exitoso y para obtener el tratamiento médico que merece, debe participar y desempeñar un papel activo en este proceso.

Si su caso es aceptado, pero su tratamiento médico ha cido negando, la compañía de seguros debe hacer lo siguiente:

1. Enviar al trabajador lesionado una copia de la carta de la decisión del "Utilization Review".
2. Enviar una copia completa de la solicitud de IMR

Una vez que reciba estos documentos sólo tiene **30 días** para firmar y devolver todos los documentos a su compañía de seguros. Usted debe hacer lo siguiente inmediatamente después de recibir este aviso de su seguro:

1. Firme el fondo de la forma de IMR solicitando una revisión del decisión negar su tratamiento.
2. Envíe la forma de IMR firmada y una copia de la carta de desmentido de la compañía de seguros al:

   DWC-IM
   c/o Maximus Federal Services, Inc.
   P.O. Box 138009
   Sacramento, CA 95813-8009

Entiendo mi responsabilidad en este proceso y firmar y devolver el formulario con una copia de la carta de rechazo al recibir.

Entiendo que si no solicito este proceso no podré recibir el tratamiento médico solicitado.

Nombre en letra de molde: _____ Firma: _____ Fecha: _____

Description of Employee's Job Duties

Employee Name: _____

Employer Name: _____

Job Title: _____

Hrs. Worked Per Day: _____ Hrs. Worked Per Week: _____

Description of job responsibilities: _____
_____
_____

Dominant Hand: Right □ Left □

Please check all that apply: As of today, you are:
Working □ Not Working □ Regular □ Modified □ Alternative □

Please check the frequency of activity required to perform your job:

Activity: (Hours per day)	**Never 0 hrs.**	**Occasionally Up to 3 hrs.**	**Frequently 3 to 6 hrs.**	**Constantly 6-8 + hrs.**
Sitting	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Bending (neck)	☐	☐	☐	☐
Bending (waist)	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Twisting (neck)	☐	☐	☐	☐
Twisting (waist)	☐	☐	☐	☐
Repetitive use of hand	☐	☐	☐	☐
Simple grasping (right hand)	☐	☐	☐	☐
Simple grasping (left hand)	☐	☐	☐	☐
Power grasping (right hand)	☐	☐	☐	☐
Power grasping (left hand)	☐	☐	☐	☐
Fine Manipulation (right hand)	☐	☐	☐	☐

Fine Manipulation (left hand)	☐	☐	☐	☐
Pushing & Pulling (right hand)	☐	☐	☐	☐
Pushing & Pulling (left hand)	☐	☐	☐	☐
Reaching (above shoulder level)	☐	☐	☐	☐
Reaching (below shoulder level)	☐	☐	☐	☐
Keyboarding with both hands	☐	☐	☐	☐

Please indicate the daily lifting and carrying requirements of your job: Indicate the height the object is lifted form the floor, table, or overhead location and the distance the object is carried.

	Never 0 hrs.	**Occasionally up to 3 hrs.**	***Lifting*** **Frequently 3-6 hrs.**	**Constantly 6-8 + hrs.**	**Height**
0 to 10 lbs.	☐	☐	☐	☐	_____
11 – 25 lbs.	☐	☐	☐	☐	_____
26 – 50 lbs.	☐	☐	☐	☐	_____
51 – 75 lbs.	☐	☐	☐	☐	_____
76 – 100 lbs.	☐	☐	☐	☐	_____
100 + lbs.	☐	☐	☐	☐	_____

	Never 0 hrs.	**Occasionally up to 3 hrs.**	***Carrying*** **Frequently 3-6 hrs.**	**Constantly 6-8 + hrs.**	**Distance**
0 to 10 lbs.	☐	☐	☐	☐	_____
11 – 25 lbs.	☐	☐	☐	☐	_____
26 – 50 lbs.	☐	☐	☐	☐	_____
51 – 75 lbs.	☐	☐	☐	☐	_____
76 – 100 lbs.	☐	☐	☐	☐	_____
100 + lbs.	☐	☐	☐	☐	_____

Please describe the heaviest item required to carry and the distance to be carried: _____
_____
_____