SAND COAST PHYSICAL THERAPY INC
Rehab Alliance
Providers of Physical, Occupational and Speech Therapy
www.RehabAlliance.com

22995 Mill Creek Dr., Suite A
Laguna Hills, CA 92653
Phone: (949) 707-5555
Fax: (888) 253-8070

We are pleased that you have selected Rehab Alliance (Sand Coast Physical Therapy Inc) for your therapy needs and will make every effort to provide you professional and therapeutic services. Please note that your Explanation of Benefits (EOB) paperwork will come with details explaining that you received therapy from Sand Coast Rehab Physical Therapy Inc. Sand Coast Rehab Physical Therapy Inc. is the company our billing is handled under, and therefore the EOB will not reference Rehab Alliance as the provider. For any further questions regarding clarification on your EOB please contact Elizabeth Proctor at 949-707-5555 Ext 4 or EProctor@rehaballiance.com.

In order to maximize the time available for your therapist to spend working on your evaluation, we ask that you observe the following department policies:

1. If you have Medicare or 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.

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 your appointment at 949-707-5555 Ext. 1 who will inform our Director of Rehabilitation.** 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 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,

Jacob Cohen, PT
Chief Executive Officer
Rehab Alliance

I have read and understand the policies above

Date:_____ **Signature:**_____

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SAND COAST PHYSICAL THERAPY INC

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.

SAND COAST PHYSICAL THERAPY INC'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. Sand Coast Physical Therapy Inc. is also required by law to have appropriate technical and administrative safeguards in place to protect your information.

USES AND DISCLOSURES OF HEALTH INFORMATION

Sand Coast Physical Therapy Inc. 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, Sand Coast Physical Therapy Inc. 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.

Sand Coast Physical Therapy Inc. 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, Sand Coast Physical Therapy Inc'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.

Sand Coast Physical Therapy Inc. 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.

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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. Sand Coast Physical Therapy Inc. 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 Sand Coast Physical Therapy Inc. 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 Sand Coast Physical Therapy Inc's health information practices or if you have a complaint, please contact the following person:

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22995 Mill Creek Dr, Suite A
Laguna Hills, CA 92653
Telephone: 949-707-5555 Ext. 1 Fax: 888-253-8070

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Patient Information and Insurance Information

Evaluation Date: _____ Date of Injury: _____

Last name: _____ First: _____ MI: _____

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

Cell phone: _____ Home phone: _____ Work phone: _____

Email Address: _____

Date of Birth: _____/_____/_____ Sex: M F Marital status: _____

Referring physician: _____ Physician phone: _____

Emergency contact: _____ Phone: _____

Relationship: _____

Primary Insurance Information

Name of primary insured _____ Policy holder date of birth: _____

Relationship to insured: _____

Employer name: _____ Occupation: _____

ID Policy #_____ Group # _____

Insurance company name: _____ Phone #: _____

Secondary Insurance Information

Name of primary insured _____ Policy holder date of birth: _____

Relationship to insured: _____

Employer name: _____ Occupation: _____

ID Policy #_____ Group # _____

Insurance company name: _____ Phone #: _____

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Authorizations

A. Consent for Treatment and Release of Pertinent Medical Information

I authorize Sand Coast Physical Therapy Inc. 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 Sand Coast Physical Therapy Inc.

B. Authorization to pay Sand Coast Physical Therapy Inc./Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to Sand Coast Physical Therapy Inc. and I am financially responsible for the non-covered services, deductibles, and co-payments. I also authorize Sand Coast Physical Therapy Inc. to release any information to process this claim.

C. Patient Information and Consent for Privacy Practices

I have received and read the Sand Coast Physical Therapy Inc Notice of Information Practices. I understand that Sand Coast Physical Therapy Inc. 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 Sand Coast Physical Therapy Inc. 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 Sand Coast Physical Therapy Inc'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**

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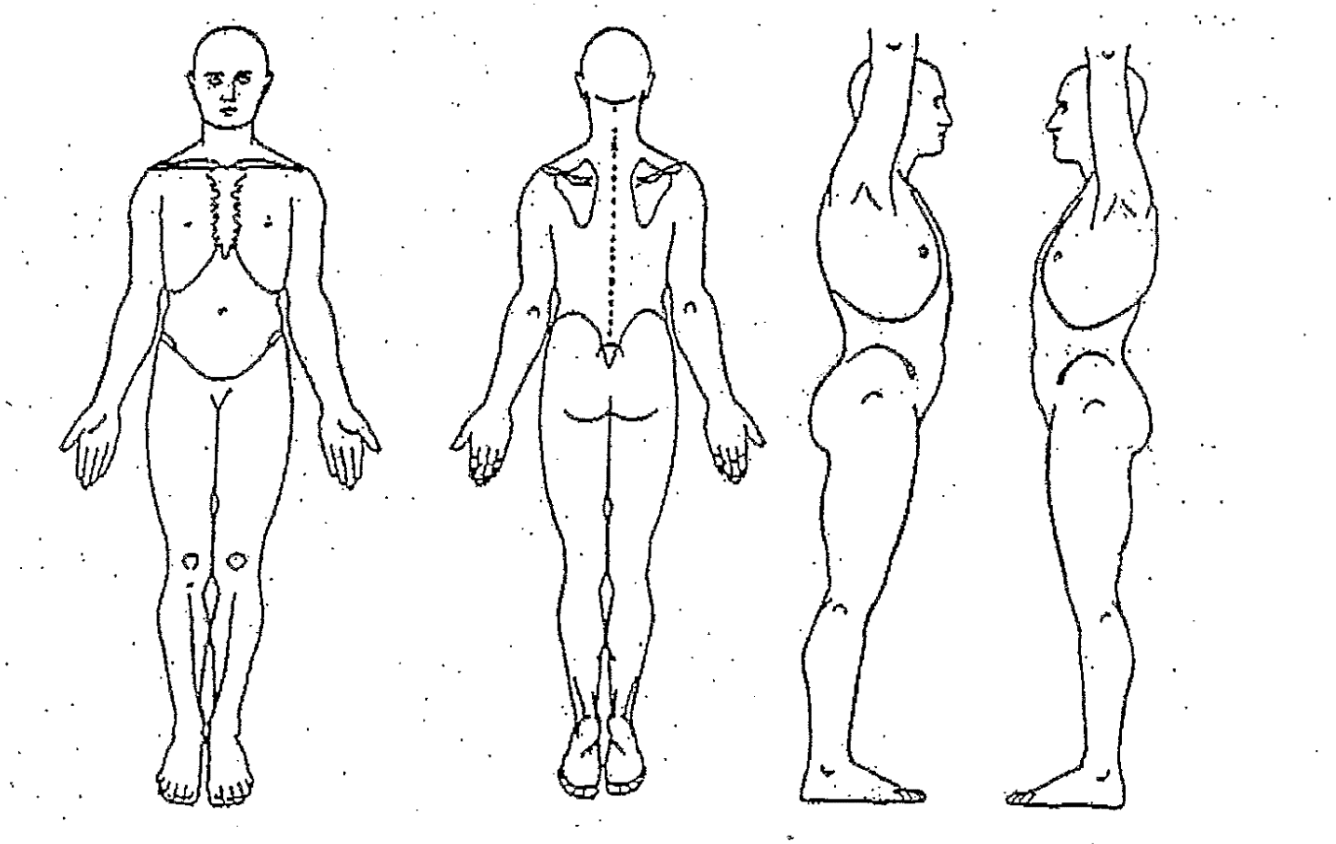
Rehab Alliance Therapy & Fitness Center
Client Intake Form

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: _____

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Medical Conditions

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

- ❑ Asthma
- ❑ Arthritis
- ❑ Blood Transfusions
- ❑ Bowel/Bladder problems
- ❑ Fractures
- ❑ Hepatitis
- ❑ Shingles
- ❑ High Cholesterol
- ❑ Hypoglycemia
- ❑ Depression
- ❑ Other: _____
- ❑ 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

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: _____

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SAND COAST REHAB PHYSICAL THERAPY

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
Building immediately on RIGHT

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