ENVISION SPORT
PHYSICAL THERAPY & PILATES

Rancho Santa Margarita Location:
23121 Antonio Parkway, Suite 100
Rancho Santa Margarita, CA 92688
Phone: (949) 713-6445 || Fax: (949) 713-6488
Irvine Location:
14150 Culver Drive, Suite 103
Irvine, CA 92604
Phone: (949) 262-9142 || Fax: (949) 262-9144
www.envision-sport.com

PATIENT INFORMATION SHEET
PLEASE PRINT CLEARLY

Patient ID No.	For Office Use Only

Patient Information		
First Name	Middle Name	Last Name
Local Address	City	State and Zip Code
Home Phone	Cell Phone	E-Mail Address
Date of Birth	Social Security Number	Gender ☐ Male ☐ Female
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Student Status ☐ Full-Time ☐ Part-Time	Occupation
How did you hear about us?		

Responsible Party Information (if different than above)		
First Name	Middle Name	Last Name
Local Address	City	State and Zip Code
Home Phone	Cell Phone	E-Mail Address
Date of Birth	Relationship to Patient	Gender ☐ Male ☐ Female

Emergency Contact 1 (if different than Responsible Party Information)		
First Name	Middle Name	Last Name
Home Phone	Cell Phone	Relationship to Patient

AUTHORIZATION OF TREATMENT

I/We hereby consent to and authorize the performance of physical therapy treatments; including, but not limited to: joint and soft tissue mobilization, exercise programs, functional exercises, Pilates, heat/ice, electrical stimulation, ultrasound, cold laser treatments and/or therapeutic taping by the staff of Envision Sport Physical Therapy and Pilates.

X _____

Signature of Patient/Guardian **Date**

CONSENT TO TREATMENT OF MINOR CHILDREN

Patient Name:	
Age:	
Diagnosis:	

I hereby authorize physical therapy services to be provided by Envision Sport Physical Therapy and Pilates on the child listed above. I agree to free Envision Sport Physical Therapy and Pilates and all of its employees of any complaints, lawsuits for damages, or complications which may follow physical therapy treatments.

X _____

Signature of Parent/Guardian **Date**

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APPOINTMENT REMINDER CONSENT

Complete this form and sign below to give your permission for Envision Sport Physical Therapy & Pilates to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

☐ Envision Sport Physical Therapy & Pilates may send email messages to confirm my upcoming appointments to _____.

☐ Envision Sport Physical Therapy & Pilates may send cell phone text messages to confirm my upcoming appointments to (____) ____ - _____.
I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

X

_____

Signature of Patient/Guardian **Date**

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MEDICAL HISTORY

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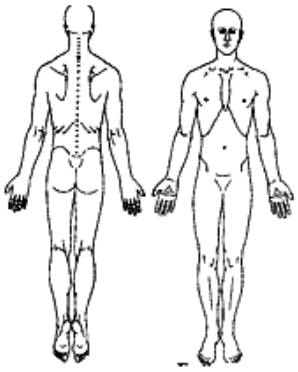
Current Injury		
Referring Physician	Date (MM/DD/YYYY) and Time Returning to Physician	
Date of Injury (MM/DD/YYYY) (If Applicable)	Date of Surgery (MM/DD/YYYY) (If Applicable)	If DOI and/or DOS is not applicable, how long has this been a problem?
Is this injury related to work? ☐ Yes ☐ No	Is this injury related to an auto accident? ☐ Yes ☐ No	If an auto accident, when and what state did the auto accident occur?
Briefly describe how the injury happened and your symptoms:		
Have you been in any form of rehabilitation **THIS YEAR** (ex: physical therapy, occupational therapy, speech therapy, chiropractic, acupuncture, etc.)? If yes, how many visits? ☐ Yes [What type of therapy?_____ # of visits:_____] ☐ No		

Self-Injury Assessment

On the diagram below, please indicate area(s) of pain/discomfort with an "X"



Medications
☐ I am not currently taking any medications
1.
2.

Allergies
☐ I have no known allergies
1.
2.

Medical History
(Have you ever been diagnosed or had the following? Please mark)

	Yes		Yes		Yes
Heart Disease		Heart Attack(s)		Seizures	
Stroke		Hepatitis A/B/C		Hernia	
Kidney Disease		HIV/AIDS		Night Sweats	
Cancer		Liver Disease		Chest Pain	
Diabetes		Gastrointestinal Disorders		Shortness of Breath	
Asthma		Changes in Sensation		Changes in Vision	
Frequent Heartburn		Dizziness/Fainting		High Cholesterol	
Chronic Headaches		High Blood Pressure		Previous Fractures	
Currently Pregnant		Metal Implants		Recent change in weight (either gain or loss)	
Pacemaker		Sensitivity to heat/ice		Smoking (how many packs/day)	
Bowel Bladder Changes		Other:		Other:	

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INSURED'S INFORMATION SHEET

Primary Insurance		
Insured's First Name	Insured's Middle Name	Insured's Last Name
Insured's Address	City	State and Zip Code
Insured's Home Phone	Insured's Cell Phone	Insured's E-Mail Address
Insured's Date of Birth	Insured's Social Security Number	Insured's Gender ☐ Male ☐ Female
Relationship to Patient		
Insured's Employer	Insured's Carrier/Company	Insured's Carrier/Company Phone Number
Insured's Insurance Identification Number	Insured's Insurance Group Number	

Secondary Insurance (If applicable)		
Insured's First Name	Insured's Middle Name	Insured's Last Name
Insured's Address	City	State and Zip Code
Insured's Home Phone	Insured's Cell Phone	Insured's E-Mail Address
Insured's Date of Birth	Insured's Social Security Number	Insured's Gender ☐ Male ☐ Female
Relationship to Patient		
Insured's Employer	Insured's Carrier/Company	Insured's Carrier/Company Phone Number
Insured's Insurance Identification Number	Insured's Insurance Group Number	

ASSIGNMENT OF BENEFITS / AUTHORIZATION OF RELEASE INFORMATION

I hereby assign and transfer the entire medical insurance benefits payments, to which I am entitled to Envision Sport Physical Therapy and Pilates. I understand that any charges that are not covered by the assignment are my sole financial responsibility. I hereby authorize Envision Sport Physical Therapy and Pilates to release any and all information acquired through my evaluation and treatment. A photocopy of this authorization is accepted as the original.

X _____

Signature of Patient/Guardian **Date**

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ATTENDANCE POLICY

Physical Therapy appointments occur 1-3 times per week during your course of treatment. As an organization, we understand that it can often be difficult to make this time commitment. Any number of events can cause the need to cancel or re-schedule your appointment. In the same breath, as a provider we make every effort to make appointments available to suit your needs. While we understand and appreciate scheduling difficulties, we must have at least a 24 hour notice if an appointment is to be canceled. This is time that we have set aside for you and as such that time is blocked off to any other patient needing to attend therapy. Given a day's notice, we are, in most, instances able to re-fill that opening with another patient. Without notice, another patient will possibly miss their opportunity for treatment.

It is important that you, the patient, arrive to your appointment on time. Arriving late to your appointment creates scheduling challenges for the front office and therapy staff. Envision Sport Physical Therapy & Pilates cannot guarantee the amount of treatment time if you are late to your expected arrival time. Furthermore, if you are more than 15 minutes late, the staff cannot guarantee physical therapy treatments can be provided at that time. At that point, you may be considered a late cancellation.

____ (Initials) I understand that my appointment is a reservation of time with a skilled healthcare professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and affects other patients as well. Appointments without sufficient notice (Less than 24 hours) will be charged a $50 fee. A no show without any notice will incur a $50 fee.

____ (Initials) I understand that if I am more than 15 minutes late to my scheduled appointment and the staff cannot accommodate my tardiness, then a $50 late cancellation fee will be charged.

____ (Initials) I understand the importance of attending my physical therapy as scheduled.

____ (Initials) My insurance does not cover these fees and it will be my responsibility to pay.

____ (Initials) If I cancel 3 appointments or no show to 2 appointments, Envision Sport Physical Therapy & Pilates has the right to dismiss and discharge me as a patient.

Credit Card Information			
Credit Card Type □ Visa □ Mastercard □ American Express	Credit Card Number	Credit Card Expiration (MM/YYYY)	CVV2 Number
Credit Card Holder's Name	Credit Card Holder's Signature X		

X

Signature of Patient/Guardian **Date**

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FINANCIAL RESPONSIBILITY POLICY

At Envision Sport Physical Therapy & Pilates, we strive to provide the best patient experience including the financial responsibility of the patient. Our office staff makes every effort to coordinate with your insurance payer to give the most accurate information regarding your physical therapy benefits.

____ (Initial) I have been either called and/or informed of my physical therapy benefits through the insurance payer I have provided to Envision Sport Physical Therapy & Pilates.

____ (Initial) I further understand that the physical therapy insurance benefits that have been provided to me are **ONLY** an estimate of benefits. The benefits provided are not a guarantee of payment and the actual patient responsibility cannot be determined until the insurance payer has processed the claim.

____ (Initial) I agree to pay for my patient responsibilities **AT THE TIME OF SERVICE**. I further understand, the services can be refused by Envision Sport Physical Therapy & Pilates if patient responsibilities are not paid at time of service. If a payment plan is necessary, arrangements can be made with the office manager prior to any services being rendered.

____ (Initial) I understand that if my insurance payer does **NOT** cover or approve payment for physical therapy services rendered by Envision Sport Physical Therapy & Pilates, then I am financially responsible for any charges and agree to pay for all charges related to the services rendered. This includes, but is not limited to claims indicating "non-covered service" or "not medically necessary."

____ (Initial) In the event of a dispute with an insurance payer, it is the responsibility of the patient to seek recourse. If the insurance carrier denies payment for services provided, it is ultimately the patient's financial responsibility to see that payment is made.

____ (Initial) I understand any checks that are returned as unpayable will be charged an additional $25 fee.

You are required to inform Envision Sport Physical Therapy and Pilates of any changes made to your insurance coverage within two weeks of the change being made. These changes include, but are not limited to changing your insurance payer and increasing or decreasing your benefits with your insurance payer. This information is vital because changes to your coverage affect copayment amounts, patient portions, as well as deductibles. As a result of changes you may be responsible paying either higher or reduced amount(s).

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS OF THE FINANCIAL REPSONSIBILITY POLICY AS IT IS WRITTEN ON THIS FORM. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL TREATMENT SERVICES RENDERED TO ME OR THE PATIENT. PAYMENT OF PATIENT RESPONSIBILITIES WILL BE MADE DIRECTLY TO ENVISION SPORT PHYSICAL THERAPY & PILATES.

X

Signature of Patient/Guardian **Date**

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form you acknowledge receipt of the Privacy Practices of Envision Sport Physical Therapy and Pilates. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at (949) 713-6445. If you have any questions about our Notice of Privacy Practices, please contact:

Darrin Yee
23121 Antonio Pkwy, Suite 100
Rancho Santa Margarita, CA 92688
Phone: (949) 713-6445
Fax: (949) 713-6488
darrin@envision-sport.com

I ACKNOWLEDGE THE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF ENVISION SPORT PHYSICAL THERAPY & PILATES.

X _____

Signature of Patient/Guardian **Date**

AUTHORIZATION TO RELEASE MEDICAL/BILLING RECORDS

I/We authorize the release of any medical records to Envision Sport Physical Therapy and Pilates. I/We also authorize Envision Sport Physical Therapy & Pilates to release any medical or billing information to the below listed persons or facilities:

Name of person/facility/doctor	Relationship to Patient	Name of person/facility/doctor	Relationship to Patient
Name of person/facility/doctor	Relationship to Patient	Name of person/facility/doctor	Relationship to Patient

X _____

Signature of Patient/Guardian **Date**

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed on if **no** signature is obtained. If it is **not possible to obtain** the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

X _____

Signature of Provider/Guardian **Date**

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PHOTO & VIDEO RELEASE FORM

OPTIONAL

You understand that while on Envision Sport Physical Therapy & Pilates premises, your, or your minor child's image (including live or recorded video images), may be used or shown on the Envision Sport Physical Therapy & Pilates website or social media outlets (Facebook, Instagram, YouTube, etc.), and that by entering the premises you consent to the use of these images. You acknowledge that Envision Sport Physical Therapy & Pilates is under continuous 24/7 video surveillance for security and training purposes.

X _____

Signature of Patient/Guardian **Date**