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**

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**

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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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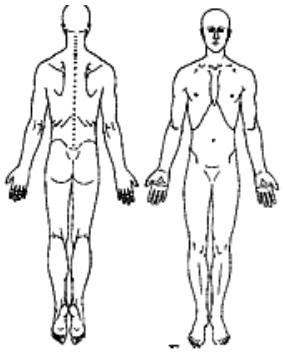
Current Injury

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"



Height (inches):	
Weight (pounds):	

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst**
Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst**

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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CURRENT MEDICATION/SUPPLEMENT LIST
PLEASE PRINT CLEARLY

Medications/Supplements

☐ I am not currently taking any medications/supplements

Medication Name (including supplements)	Dosage (mg, mg/mL, etc.)	Frequency (Times/Day)	Route of Administration (Orally, etc.)
Example: Baby Aspirin	81 mg	1x/day	Orally
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

I certify that the above medication list provided is true and complete to the best of my knowledge and I understand that Envision Sport Physical Therapy & Pilates uses the above information for my care. Should any medications or supplements change, I will notify Envision Sport Physical Therapy & Pilates.

X

Signature of Patient/Guardian **Date**

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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

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UNDERSTANDING MEDICARE BENEFITS

Medicare regulations for Outpatient Physical Therapy are the following:

- ALL therapy services are subject to a $2,040 allowable amount therapy cap, which includes both patient responsibility and payment from Medicare.
    - This cap is NOT per injury and is a hard cap for all therapies (including but not limited: physical therapy, speech-language pathology services in all setting types) combined during the calendar year.
- ALL therapy services between $2,040 - $3,000 will be allowed with the understanding that services being rendered by the provider are **medically necessary**.
- ALL therapy services beyond $3,000 will be subjected to a targeted medical review process.
    - The medical review process states that services are **reasonable and necessary**, prescribed by a physician, and there is a need for **skilled** services.
- If services are clinically deemed medically necessary by the physical therapist and physician, the services must be billed to Medicare and patient cannot be charged any cash rates.

Other notes:

- There is NO guarantee of payment with Medicare benefits. Benefits are reviewed at the time of service and must be medically necessary for Medicare to cover services
- Supplemental insurance will not provide additional benefits if Medicare denies claims.
- Some secondary insurance will allow additional benefits if Medicare denies claims, but the patient is responsible for any deductibles, co-payments/co-insurances.
- If patient does not have a secondary and/or supplemental insurance, the patient will be responsible for the deductible and co-insurance. The only exception to this will be Qualified Medicare Beneficiary (QMB).
- If services are not medically necessary or not covered by Medicare, an Advanced Beneficiary Notice can be signed by the patient and cash rates may apply.

At Envision Sport Physical Therapy & Pilates we aim to uphold the highest level of physical therapy service and maintain compliance with Medicare regulations. Please understand that if Medicare or a secondary insurance denies payment for services provided, it is ultimately the patient's financial responsibility to see that payment is made for rendered physical therapy treatments at Envision Sport Physical Therapy & Pilates.

I HAVE READ AND UNDERSTAND THE STATEMENT OF THE MEDICARE OFFICE POLICY AS IT IS WRITTEN ON THIS FORM. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL TREATMENT SERVICES RENDERED TO ME.

X _____

Signature of Patient/Guardian **Date**

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STATEMENT OF OFFICE POLICY

As you begin physical therapy treatment here, we hope there is a mutual understanding of the payment for services. We make every effort to obtain a quote for your insurance benefits and relay those figures to you. It is explained to us as we receive this quote that it is an estimate and not a guarantee of payment. It is virtually impossible for any insurance company to quantify payment prior to receiving our claims for services provided. When we quote your benefits, we are simply reiterating those figures given to us by your insurance carrier. **There is no guarantee that the quoted percentage obtained by telephone will be the actual benefits paid after receiving our claim.**

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 company/ provider and increasing or decreasing your benefits with your current insurance company/ provider. 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).

In the event of a dispute with an insurance carrier, 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. We will make determined efforts to secure proper insurance payment for the treatment you receive, and we will ask that you also contribute your time and energy to facilitate the process.

I HAVE READ AND UNDERSTAND THE STATEMENT OF OFFICE POLICY AS IT IS WRITTEN ON THIS FORM. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL TREATMENT SERVICES RENDERED TO ME.

X _____

Signature of Patient/Guardian **Date**

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**