Southern California Orthopedic INSTITUTE

Center for Rehabilitation Medicine

Patient Information Sheet

Birthday: _____ SS #: _____

Referral Source: Physician Phonebook Self Insurance Website Patient
Other: _____

Patient Name: _____*

Patient Address: _____*

_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Referring Physician Name: _____*

Referring Physician Address: _____

Referring Physician Phone #: _____

Primary Insurance: _____*

Primary Insurance ID: _____ Group: _____

Employer: _____

Employer Address: _____

Business Phone: _____ Spouse Name: _____

Emergency Contact:_____*

Contact Phone #: _____*

Work Comp

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

Date of Injury: _____

Work Comp Carrier: _____ Claim # _____

Work Comp Adjuster/Nurse: _____

Work Comp Carrier Phone #: _____

SCOI CRM Patient Medical Questionnaire

Patient Name:	Today's Date:	Date of Birth:	Referring Physician:

What brings you to Therapy Today:

Date of Injury:	How were you Injured:

Were x-rays/MRI/CT Scans Taken?: [ ] yes [ ] no	If yes, can you provide date(s) done and any results you might have been told:

Did you have surgery for this condition?: [ ] yes [ ] no	Date of Surgery:	Surgery Performed:
	Surgeon:	

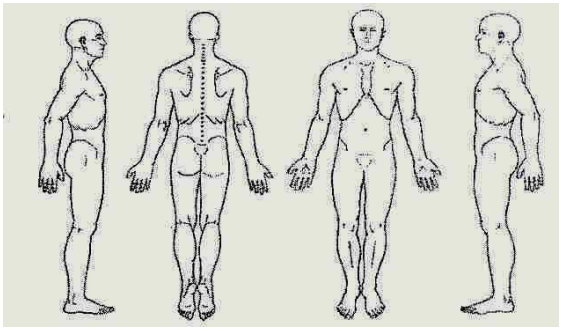
Since the date of injury your symptoms are: [ ] improved [ ] Staying thee same [ ] Worse

Please list any medications taken for this problem:

Please list any other medications you are taking:

Have you received treatment for this problem: [ ] yes [ ] no
If yes, where: How many treatments did you receive?:

Please note on the body drawings to the right:
1. Where the pain is
2. Where the pain travels to



What makes your pain worse:

Pain is worse: [ ] morning [ ] afternoon [ ] night time

Past Medical History (please mark "yes" if you have been diagnosed with the condition)

High Blood Pressure	[ ] yes [ ] no	Arthritis	[ ] yes [ ] no
Heart Attack	[ ] yes [ ] no	Lung Conditions	[ ] yes [ ] no
Pacemaker	[ ] yes [ ] no	Kidney Disease	[ ] yes [ ] no
Stroke	[ ] yes [ ] no	Hepatitis	[ ] yes [ ] no
Seizure Disorder	[ ] yes [ ] no	AIDS	[ ] yes [ ] no
Diabetes	[ ] yes [ ] no		
Cancer	[ ] yes [ ] no	other:_____	
Pregnant	[ ] yes [ ] no		

Please give information on any "yes" marked above:

Please list any surgeries received Not related to this problem:

What are your goals for treatment?:

Patient Signature:_____ Date:_____

Patient Representative:_____ Relationship:_____ Date:_____

Therapist Signature:_____ Lic. #:_____ Date:_____

Southern California Orthopedic Institute
Financial Policy

Welcome To Our Office

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. If you have questions about your account, charges, insurance, or payments, please speak with one of our Billing Representatives.

Please have available at the time of your visit the following insurance and identification information:

1. Your insurance identification card so that we may copy the front and back of the card for accurate insurance information.
2. Your drivers license so that we may copy the card for accurate demographic and patient specific data.
3. If you have a health plan that requires its own insurance claim form, please provide us with a signed and completed claim form.
4. Your referral or authorization for services when applicable.

Payment Policy

Payment in full is expected at the time service is rendered. For your convenience, we accept cash, check, or credit cards. We will bill those insurance companies with which we have an agreement. Please note that in the event of non-payment, the account may be placed with an outside collection agency and the expenses will be added to your account balance. Balances that exceed 90 days from the date of service may be charged a finance fee of 1.5% per month. If you have any questions, please feel free to ask one of our representatives or our Billing Service.

Self-pay Accounts

If you do not have a valid insurance plan to cover the cost of our services, you will be required to make full payment at the time of service.

Insurance Plans

If you are insured, we will bill those insurance plans with which we have an agreement. However, it is ultimately your responsibility to become familiar with the details of your insurance plan coverage. We recommend you contact your insurance company prior to any service so you may understand your allowable benefits. If you have a PPO or HMO insurance plan, we will collect the required co-payment, co-insurance, and any deductible that is due at the time of the visit. In the event that your health plan determines a service to be “non-covered,” we will bill you, and payment is due upon receipt of that statement. Any amount not paid by your insurance company within 30 days will be billed to you. If your insurance coverage is with a plan that we do not have an agreement, payment is expected, in full, at the time of service. As a courtesy, we will submit a claim to your insurance company on your behalf.

Medicare

Your physician may or may not be a participating Medicare provider. If your physician is a participating provider, we will bill your Medicare insurance and your supplemental, if you have one.

Third Party Liability Injuries

For patients who have been involved in a liability/third party accident, payment in full is expected at the time of service.

Workers' Compensation

If you are involved in an "on-the-job" work injury, prior to seeing the physician, the following information must be obtained and verified prior to your visit:

- Date of Injury
- Case or claim number
- WCAB#, if applicable
- Workers' Compensation carrier information
- Adjuster's name
- Adjuster's telephone number
- Employer

Insurance Updates

Due to frequent changes in insurance plans and the benefits offered under those plans, our staff is required to review and update your insurance information on a regular basis.

Other Fees

- Copy of Records
- Copy of X-rays
- Form Completion Fees

I understand that SCOI agrees to bill my insurance as a courtesy and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for payment for all services.

_____	_____	_____
Name of Patient (please print)	Signature of Patient or Responsible Party	Date

_____	_____	_____
Interpreter/Representative Name	Interpreter/Representative Signature	Date