BAY AREA
Rehab & Medical, Inc.
Help for the Federal Injured Workers

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:	Date of injury: / /
Employer's address:	OWCP Case #:
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? ____________________

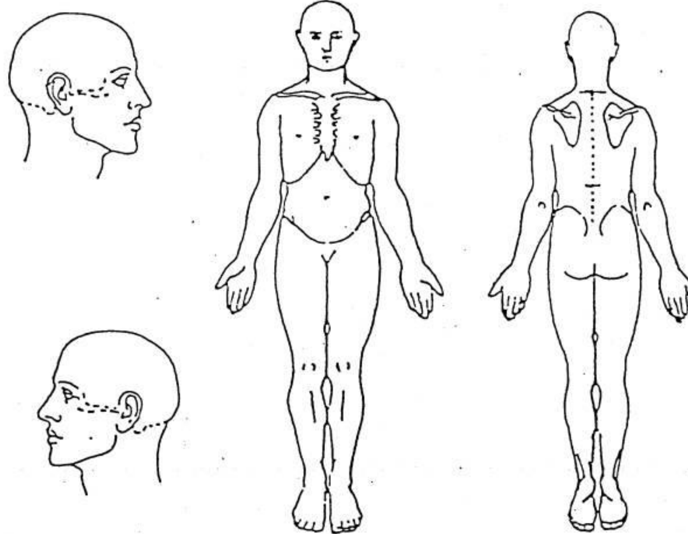
Number of visits and body parts treated: ______________________________

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: ______

____

Bay Area Rehab and Medical
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 Bay Area Rehab & Medical ("Provider") will be decided and resolved through arbitration by the Alameda 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 Alameda, 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: **Bay Area Rehab & Medical**	**Patient:**	**Parent/Guardian** (if pt is a minor)
Signature Date	Signature: Date	Signature Date
Printed name and title	Printed Name	Printed Name

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

OF-011 Rev. 10/03

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.

			Lifting		
	Never 0 hrs.	**Occasionally up to 3 hrs.**	**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.	☐	☐	☐	☐	________

			Carrying		
	Never 0 hrs.	**Occasionally up to 3 hrs.**	**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: ______________
____
____

Bay Area Rehab and Medical, Inc.

34261 Fremont Blvd., Fremont, Ca 94555 (510) 796-1288

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

__________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

____
Name of Individual (Printed)

____
Signature of Individual

____
Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

____
Relationship

Date Signed ____/____/____

Witness: __________________________

BAY AREA
Rehab & Medical, Inc.
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CONSENT for COMMUNICATION via E-MAIL
(Provider-Patient)

I, _________________________, hereby consent to have my physician, Bay Area Rehab and Medical,Inc. communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mailing regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff, or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Signature _______________________________ Date ___________________________