PATIENT INFORMATION SHEET Private Insurance/Work Comp/Personal Injury/Medicare

Patient Name: _____

Home Address: _____

City: _____ State: _____ Zipcode: _____

Date of Birth: ____/____/_____ Age: _____ Home Phone (____) ____ - _____
Home Phone (_____) _____ - _____ Cell Phone (____) ____ - _____
Social Security #: _____-_____-_____ Referring Physician: _____
Referring Physician Address: _____
Home Phone: (_____) _____ - _____ (Physician PIN#: _____)

Employer: _____
Address of Employer:_____
City: _____ State: _____ Zipcode: _____

Contact in case of Emergency: _____ Relationship: _____
Phone number (of emergency contact person): (_____) _____ - _____
Spouse: _____ Social Security #: (spouse): _____-_____-_____

Insurance Carrier: _____
Claims Mailing Address: _____
City: _____ State: _____ Zipcode: _____
Policy Number: _____ Group Number: _____
Adjuster: _____ Phone Number: (____) ____ - _____
Case Manager: _____ Phone Number: (____) ____ - _____
Primary Insured: (self, spouse, parent): _____

Secondary Insurance Carrier: _____
Claims Mailing Address: _____
City: _____ State: _____ Zipcode: _____
Policy Number: _____ Group Number: _____

Workers Compensation Claim Number/IPA Authorization #: _____
Date(s) of Injury (if applicable): _____
Location of Injury: (if applicable): _____ Date last worked: _____
Attorney Name: _____ Phone Number: (____) ____ - _____
Attorney Address: _____

Assignment of Benefits: I hereby authorize all payment which I am entitled to for the medical treatment and services, including major medical and supplemental benefits relative to the services reported to the physician or medical group, California Rehabilitation, Inc. I understand visit and procedure fees are available upon request. I understand that I am financially responsible to said medical clinic for charges not covered by this assignment. I understand that procedure reports and evaluation reports may accompany routine billing procedures and I authorize release of all information which is requested by the insurance company concerning my treatment, illness or injury.

Date: ____/_____/_____ Patient's Signature _____

If you have insurance cards, please let us copy them

L. Scott Stoney, M.D. ***CALIFORNIA REHABILITATION, INC.
Physical Medicine and Rehabilitation

361 Hospital Rd, Suite #425
Newport Beach, CA 92660
(949) 548-4580

CONSENT FOR TREATMENT

I authorize and direct my physician, their associate, or medically authorized representative to render therapeutic procedures or treatments that in their medical judgments may be advisable for my wellbeing. The risks, possible alternatives and possible complications along with the nature of the treatments and procedures have been explained to me to my satisfaction. No warranty or guarantee has been made as to the end results of my care.

I know that no services will be rendered to me without the review and signing of the legal arbitration agreement and consents for treatment and being signed and dated, prior to receiving those services.

California Rehabilitation maintains medical personnel and facilities to assist your physician and surgeons in the performance of various medical and surgical procedures. There treatments may involve the possibility of unsuccessful results to include complications, disability, injury or even death from both known and unknown causes, from both see and unforeseen causes. No warranty is made or implied as to the guarantee results or cure. You may have the right to be informed by your physician as to the risks as well as the nature and purpose of the treatment and the available alternative methods of treatments. Except in cases of emergency, operations or procedures are not performed until the patient has the opportunity to receive all pertinent information and explanations. You have the right to obtain a second opinion or to refuse any proposed treatment or procedure.

Your physician, Dr. Stoney, has recommended, or will be recommending, treatments during your course of care. These treatments and procedures will be performed by supervising physician and surgeon named above or his designee together with associates and assistances form the medical staff of California Rehabilitation, Inc. In the event of an emergency, I hereby authorize California Rehabilitation, Inc. to provide medical care through their office, utilizing the authorized office staff as well as appropriate personnel from hospital facilities.

YOUR SIGNATURE BELOW CONSTITUTES YOUR ACKNOWLEDGEMENT AND CONSENT:

A. I HAVE READ AND AGREE TO THE POLICIES, CONDITIONS AND THE INFORMED CONSENT
B. I WILL REQUEST ALL DESIRED INFORMATION CONCERNING MY TREATMENT, CARE AND BILLING YOU RECEIVE THROUGH CALIFORNIA REHABILIATION, INC.

Today's Date: _____/_____/_____ **_____**

Patient's printed name in full

Patient or responsible party's signature

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ASSIGNMENT OF INSURANCE BENEFIT

I HEREBY AUTHORIZE ALL INSURANCE PAYMENTS FOR WHICH I AM ENTITLED, TO BE FORWARDED DIRECTLY TO **L. SCOTT STONEY, M.D. OR CALIFORNIA REHABILITATION, INC.** FOR THE FOLLOWING SERVICES TO INCLUDE:

Medical, surgical, diagnostic, therapeutic AND physical medicine, laboratory, primary care and consulting services rendered to me, my spouse, or my dependent child(ren). These benefits shall include procedures performed UPON me, my dependent spouse or child(ren) for those services rendered on an outpatient or inpatient basis. I further understand that I am financially responsible for any and all services rendered me, my spouse or dependent child(ren) that may no be covered by my insurance company.

I agree to notify **Dr Stoney OR the representative of L. Scott Stoney, M.D. Also known as California Rehabilitation, Inc.,** if my insurance changes or is terminated for any reason. I further agree to assist the billing department with denied services, difficult to pay claims, appeals, quick response submission of requested information for your insurance carrier or physician's billing department, and authorized/retroactive authorizations for services rendered.

I authorize the release of information which may be requested by my insurance carrier for the purposes of processing and payment of medical services. Procedure reports and evaluation reports may routinely accompany billed procedures to show medical necessity and progress and to expedite reimbursements.

Offices fees for Initial Evaluations, Initial Consultations, as well as follow-up are as follows:

Initial Comprehensive Evaluation	*$300.00*
Initial Limited Evaluation	*$150.00*
Follow-Up Extended Evaluation	*$300.00 - $500.00*
Follow-Up Limited Evaluation	*$150.00*

Today's Date: _____/_____/_____ **_____**

Patient's printed name in full

Patient or responsible party's signature

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OFFICE POLICY, PROCEDURES

1. Payment for services rendered for each office visit and procedure are due prior to services provided unless prior arrangements have been made. ALL HMO, PPO, EPO and IPA contracted plan policies will be observed. Those patients must pay their co-payments and deductibles prior to services being rendered at each of their scheduled appointments. Insurance forms will be completed as a courtesy to the patient when needed, however additional fees will be required if any completed forms have been lost or destroyed by the patient
2. Changes in appointment times or cancellations must be made at least 24 hours in advance or a charge equivalent to a regular office visit or Physical Therapy visit will be accessed and billed to the patient or responsible party directly. THIS IS NOT A BILLABLE CHARGE FOR YOUR INSURANCE CARRIER!!!
3. Please Note: The ultimate success and outcome of Physical Therapy, surgical and diagnostic procedures will show the best results for you by complete co-operation and participation of ALL advisement prescribes for you. This means patient full participation and compliance. Even with full compliance and follow through, there are no guarantees as to the outcome and degree of healing and wellness. The outcome should be accesses according to your specific medical condition and not that of others.
4. Obtaining those medication prescribes for you is your responsibility. You must utilize your individual funds or insurance plans to purchase prescribed medication. You are responsible for lost prescriptions and loss of medications once your prescription has been filled by your pharmacist. Therefore, please be sure to treat your prescriptions and medications with care. Prescription replacements for these reasons will not be honored unless under emergent circumstances. Refills that have been previously discussed during office visits may be easily refilled by having your neighborhood pharmacist contact our office. If you have missed appointments or have not followed-up otherwise with the doctor, refills will not be authorized and you will be referred to our office to schedule the next available appointment.
5. All written and verbal materials related to past, current or future treatments are considered confidential and are not available to other individuals without your express written consent. Reports to referring or primary care physicians regarding plan of treatments and status reports may periodically be forwarded for authorization of continued care and treatment and as a courtesy to the referring physician. When billing your insurance carrier for special procedures, it may be necessary to attach appropriate documentation of the examination with the diagnosis, procedures, and the prognosis or disability data.

Today's Date: _____/_____/_____ _____

Patient's printed name in full

_____

Patient or responsible party's signature

L. Scott Stoney, M.D. ***CALIFORNIA REHABILITATION, INC.
Physical Medicine and Rehabilitation

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PATIENT CONSENT FOR USE AND DISCLOURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for California Rehabilitation, Inc to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (California\ Rehabilitation, Inc.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. California Rehabilitation, Inc reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to California Rehabilitation, Inc Privacy Officer at [*361 Hospital Rd Suite 425, Newport Beach CA 92663*].

With this consent, California Rehabilitation, Inc may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, California Rehabilitation, Inc may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, California Rehabilitation, Inc may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that California Rehabilitation, Inc restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions to California Rehabilitation, Inc, but if it does, it is bound by this agreement. By signing this form, I am consenting to California Rehabilitation, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, California Rehabilitation, Inc my decline to provide treatment to me.

Signature of Patient or Legal Guardian

Today's Date: _____/_____/_____ **_____**

Patient's Name

Print Name of Patient or Legal Guardian

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Physical Medicine and Rehabilitation

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RECIEPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOLEDGEMENT FORM

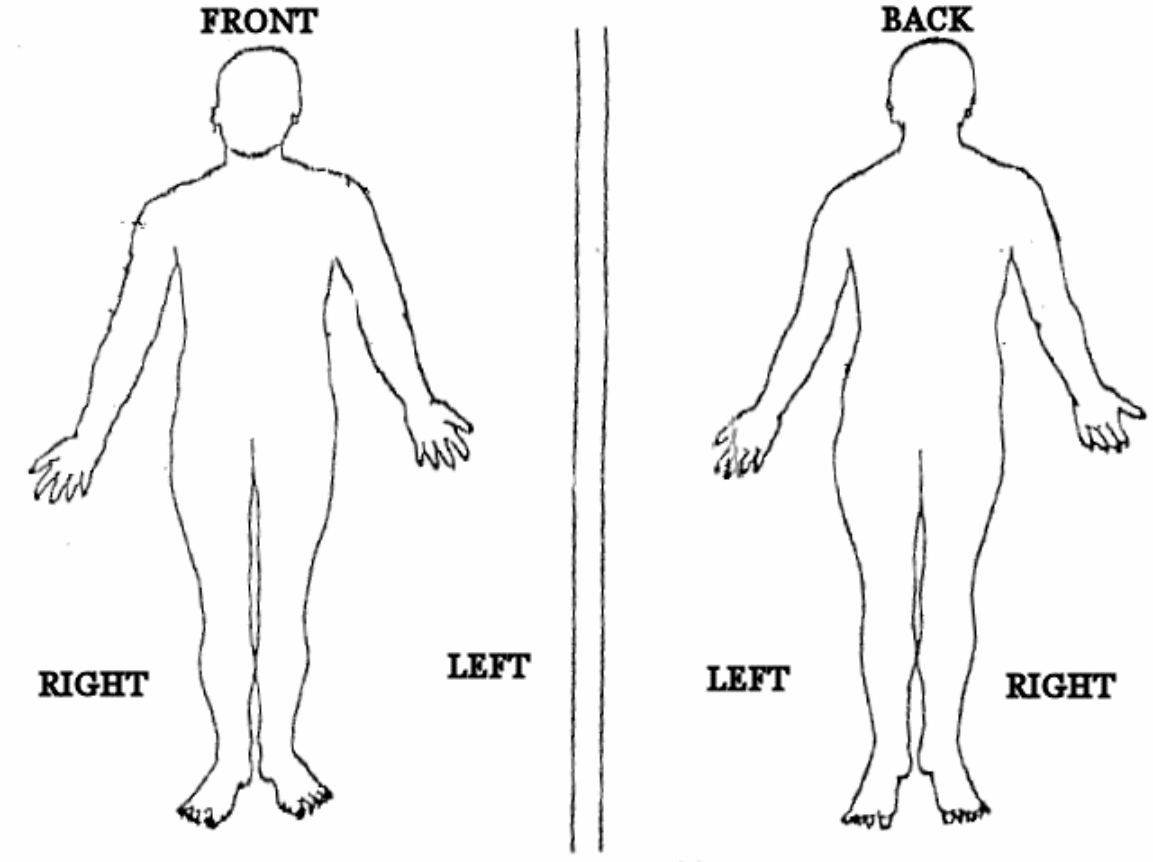
I, _____, have received a copy of
Patient Name

_____'s Notice of Privacy Practices.
Patient Name

Today's Date: _____/_____/_____

Patient or responsible party's signature

Please mark appropriate symptom (Pain **xxx** numbness as **00000)**



Please indicate how the following factors affect your pain:

	WORSE	BETTER	NOT EFFECTED
Standing	_____	_____	_____
Walking	_____	_____	_____
Sitting	_____	_____	_____
Driving	_____	_____	_____
Lying Down	_____	_____	_____
Nights	_____	_____	_____
Lifting	_____	_____	_____
Arising from a chair	_____	_____	_____
Housework (vacuuming, making beds)	_____	_____	_____
Coughing	_____	_____	_____
Sneezing	_____	_____	_____

Please indicate previous treatments you have received:

___ Bedrest ___ Muscle relaxants ___ Physical Therapy
___ Traction ___ Aspirin ___ Chiropractic Manipulation
___ Hospitalization ___ Cortisone Injection ___ Acupuncture/acupressure
___ Heat ___ Surgery ___ Biofeedback
___ Ice ___ Corsets or braces ___ Neurostimulator (TENS)
___ Pain Medications ___ Exercise ___ Chymopapain
___ Other _____

Which is more troublesome to you? Back Pain_____ Leg Pain_____
How would you break down the components of your problem?

Back _____%
Right Leg _____%
Left Leg _____%
TOTAL _____100%

Does the pain occur every day? Yes _____ No _____
How frequent is the pain? Comes and Goes _____ Constant _____
How severe is the pain no compared to when it began?
Better ____ Same ____ Worse ____

Do you have weakness in your legs? Yes _____ No _____
If yes, describe _____

Is there a limit to how far you can walk? Yes _____ No _____
If yes, describe _____

Has your ability to urinate changed? Yes _____ No _____
If yes, describe _____

Are you able to control bowel movement? Yes _____ No _____
If no, describe _____

Does the pain prevent sleep or awaken you at night? Yes _____ No _____
If yes, describe _____

Have you missed time from work due to pain? Yes _____ No _____
What kind of work do you do? _____
Recreational activities include: _____
Has the pain interfered? Yes _____ No _____

Severeity of pain is:

_____Slight and occasional, causing no compromise in daily activities.
_____Mild, having no effect on ordinary activity, but occurring with or after vigorous activity
_____Moderate and tolerable, requiring restrictions in daily activities.
_____Severe, causing significant disability.

DRUG USE QUESTIONAIRE (DAST-20)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is “Yes” or “No”. Then, circle the appropriate response beside the questions.

In the statements “drug abuse” refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

For information on the DAST, contact Dr. Harvey Skinner at the Addiction Research Foundation, 33 Russell St., Toronto, Canada, MSS 2S1.

These questions refer to the past 12 months.

Circle your Response

1. Have you used drugs other than those required for medical reasons?.....Yes No

2. Have you abused prescription drugs?.....Yes No

3. Do you abuse more than one drug at a time?.....Yes No

4. Can you get through the week without using drugs?.....Yes No

5. Are you always able to stop using drugs when you want to?.....Yes No

6. Have you had "blackouts" or "flashbacks" as a result of drug use?.....Yes No

7. Do you ever feel bad or guilty about your drug use?.....Yes No

8. Does your spouse (or parents) ever complain about your involvement with drugs?.....Yes No

9. Has drug abuse created problems between you and your spouse or your parents?.....Yes No

10. Have you lost friends because of your use of drugs?.....Yes No

11. Have you neglected your family because of your use of drugs?.....Yes No

12. Have you been in trouble at work because of drug abuse?.....Yes No

13. Have you lost a job because of drug abuse?.....Yes No

14. Have you gotten into fights when under the influence of drugs?.....Yes No

15. Have you engaged in illegal activities in order to obtain drugs?.....Yes No

16. Have you been arrested for possession of illegal drugs?.....Yes No

17. Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?.....Yes No

18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?.....Yes No

19. Have you gone to anyone for help for a drug problem?.....Yes No

20. Have you been involved in a treatment program specifically related to drug use?.....Yes No

Adult History Form

Date of Birth:	Home Phone:	Work Phone:

Please list **SPECIAL PROBLEMS** you would like evaluated today in order of significance:

1.

2.

3.

4.

MEDICATION ALLERGIES: (such as penicillin) What happens when you take that medicine:	**OTHER ALLERGIES:** (such as bees/wasps, foods, latex, etc) What happens when you are exposed:

MEDICATIONS: Prescription and Non-Prescription
(Including aspirin, vitamins, birth control, herbs, supplements, etc.)

PAST MEDICAL HISTORY

Please describe and give dates of any illnesses, injuries, hospitalizations, and surgeries:

IMMUNIZATIONS

Hepatitis B Yes No Date:	Hepatitis A Yes No Date:	
Tetanus Yes No Date:	Influenza (flu) Yes No Date:	"Pneumonia Shot" Yes No Date:

Have you had Chickenpox? Yes No Date:	MMR (Measles, Mumps, Rubella) Yes No Date:
Have you ever had a test for Tuberculosis? Yes No Date:	If yes (circle one): Positive / Negative
Have you ever had a blood transfusion? Yes No	If yes, Dates:

Provider Comments

Initials: Date:

Provider:_____ **Date:**_____-_____-_____

Patient:_____ **DOB:**____-____-____ **Age:**____

Adult History Form

Provider Comments

FAMILY HISTORY

Please check any family members who have the following health problems.

	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes						
Glaucoma						
Cancer (List Type)						
Heart Attack						
Angina						
Stroke						
High Blood Pressure						
High Cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Mental Illness						
Suicide						
Other Health Problems						

SOCIAL HISTORY

Spouse's Name:	Spouse's Occupation:
Ages of Children:	# of People in Household:
Your Occupation:	Place Employed:
Level of Education:	Hobbies:

Recent Significant Changes in Your Life? Yes No

Financial Hardships? Yes No

Have Special Stresses in Your Life? Yes No

I am **NOT** happy with (circle those that apply) → Myself My Health My Work My Partner My Life

→ Because violence is so common in many people's lives, I've begun to ask all my patients about it.

Have you Been in An Abusive Relationship?	Yes	No
Does your partner ever hit you, hurt you, or threaten you in any way?	Yes	No
Has your partner ever forced you to have sex when you didn't want to?	Yes	No
Are you ever frightened of you partner?	Yes	No
Has anyone ever hit you, hurt you, or threatened you in the past?	Yes	No

Have you ever used **tobacco products** regularly? Yes___ No___ If yes, please continue below:

Tobacco Product	Age Started Using	# of Years Used?	Amount Each Day	Still Use?

Circle the **beverages** you regularly consume and list the amount per WEEK:

Coffee/Tea: Beer: Wine: Hard Liquor: Soda:

Initials: Date:

Provider:_____ **Date:**_____-_____-_____

Patient:_____ **DOB:**_____-_____-_____ **Age:**_____

Adult History Form

Provider Comments

Drugs and Alcohol can sometimes affect your health and the medications you take.
Please answer the following:

1. In the last year, how many times have you not remembered things that happened while you were drinking or using drugs?	5 or more 3-4 1-2 0
2. In the last year, have you ever drunk or used drugs more than you meant to?	Yes No
3. Have you felt you wanted to or needed to cut down on your drinking or drug use in the last year?	Yes No
4. In the last year, have you drunk or used non-prescription drugs to deal with you feelings, stress, or frustration?	Yes No
5. As a result of your drinking or drug use, did anything happen in the last year that you wish didn't happen?	Yes No

ORGAN DONATION: Do you want to be an Organ Donor? Yes No Don't Know

ADVANCED DIRECTIVES: Do you have an advanced directive or living will: Yes No

CURRENT HEALTH PRACTICES

Food, exercise, and safety can all play a role in your health.
Please answer the following questions to see what areas might put you at risk.

Do you exercise regularly? Yes / noType of exercise and frequency:

How many meals do you eat per day? Snacks per day?

How many meals do you eat out per week?

Amount and type of **dairy products** you consume per day:

List any nutrition or diet concerns you would like help with:

If you are on a **special diet**, please explain:

Are you happy with your weight? Yes No

Do you have regularly **Dental** check-ups? Y___ N___ How often do you brush/day ____ floss____

Do you wear a seatbelt: Always___ Sometimes____ Never____

Do you ride a motorcycle? Y___ N___ Bicycle? Y___ N___ Ski/Snowboard? Y___ N___
Skateboard? Y___ N___
If yes, do you wear a helmet? Y___ N___

Have you been exposed to a **Toxic Substance**, such as asbestos, DES, radiation, chemicals? Yes___ No___
If Yes, please explain:

Do you have a **smoke detector** in the home: Y___ N___ When was it last checked?

Initials: Date:

Provider:_____ **Date:**_____-_____-_____

Patient:_____ **DOB:**_____-_____-_____ **Age:**_____

Adult History Form

Provider Comments

REVIEW OF SYSTEMS

Circle those items you currently have significant problems with, and describe:

GENERAL

Recent Weight Change	Increase Thirst or Urination	Night Sweats/Hot Flashes
Always Hot/Always Cold	Rashes or Skin Problems	Significant Fatigue
Do you have chronic pain problems? Yes No		

BREASTS: Men & Women

Lumps/Tenderness	Do you Do Monthly Self Breast Exams? Y___ N___
Drainage from Nipple	Month and Year of last Mammogram:

EYE, EAR, NOSE & THROAT

Glaucoma	Blurred or Double Vision - Ever	Use Glasses or Contact Lenses
Hearing Loss	Brief Loss of Vision - Ever	Use Dentures (Partial or Total)
History of Radiation Therapy to Head or Neck		Teeth or Gum Problems

CARDIOPULMONARY

Shortness of Breath with Activity	Dizziness	Chest Pain
Daily Sputum (Phlegm) Production	Coughing Up Blood	Heart Palpitations
Difficulty Breathing While Lying Flat	Leg Cramps While Walking	Wheezing
Waking Up Short of Breath	Daily Cough	Ankle Swelling

GASTROINTESTINAL

Change of Appetite	Abdominal Pain	Blood in Stool/Black Stool
Difficulty Swallowing	Diarrhea/Constipation	Frequent Nausea/Vomiting
Heartburn	Indigestion From Fatty Foods	

NEUROPSYCHIATRIC

Frequent Disabling Headaches	Difficulty Sleeping	Tremors
Frequent Anxiety or Anxiety Attacks	Memory Loss	Passing Out/Fainting
Treated in Past for Emotional or Psychological Problems: Please describe_____		Often Feel Sad or Depressed

MUSCULOSKELETAL & SKIN

Frequent Neck or Back Pain	Muscle Pain	Disabling Night Leg Cramps
Joint Problems	Use a Brace or a Splint	
Mole that has changed color, size, shape, or won't heal? Yes No		

GENITOURINARY: MEN & WOMEN

Urinary Tract Infections	Sores in the Genital Area
Difficult or Painful Urination	Blood in Urine
History of Kidney or Bladder Stones	Urination More Than Once a Night
History of Four or More Sex Partners	Sexual Intercourse Before 18 years old
Method of Birth Control:	
Have you ever had any Sexually Transmitted Diseases: Yes___ No___	

GENITOURINARY: MEN ONLY

Pain or Lump in Testicles/Scrotum	Do you do Self Testicular Exams: Yes___ No___

GENITOURINARY: WOMEN ONLY

Age of first Period	Frequency/Length of Menstrual Periods:
Date if Last Menstrual Period:	Change in Menstrual Pattern
Number of Pregnancies:	Number of Children:
Disabling Menstrual Cramps	Unusual Vaginal Discharge/Itching
Date of Last Pap Smear:	
History of Abnormal Pap Smears: Y N	Any Treatments for Abnormal Pap:

Initials: Date:

Provider:_____ **Date:**_____-_____-_____

Patient:_____ **DOB:**_____-_____-_____ **Age:**_____

Adult History Form

Sexual Health is an important part of an individual's overall physical and emotional well-being. If I don't ask about Sexual Health, patients will not always bring the issue up during the interview. Therefore, I've begun asking all patients about their Sexual Health.

Male Sexual Health

Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health.
Following are several questions regarding sexual function.
Place an "X" on the line where your answer to the question would be.

1. How do you rate your confidence that you could get and keep an erection?

   Very Low ---------- Very High

2. How Often are your erections hard enough for penetration (entering your partner)?

   Rarely ---------- Almost always or always

3. How often were you able to maintain an erection after penetration (entering your partner)?

   Rarely ---------- Almost always or always

4. How difficult was it to maintain your erection to completion of intercourse?

   Very difficult ---------- Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?

   Never satisfactory ---------- Almost always or always

6. Is sexual intercourse usually painful? Yes No

Female Sexual Health

Please answer the following questions as truthfully as possible.

1. In the past month, did you **usually** feel sexual aroused ("turned on") during sexual activity or intercourse?	Yes No
2. In the past month, have you been **satisfied** with the amount of vaginal lubrication ("wetness") during sexual intercourse?	Yes No
3. In the past month, when you had sexual stimulation or intercourse, did you **usually** reach orgasm (climax)?	Yes No
4. In the past month, have you been **satisfied** with your sexual relationship with your partner?	Yes No
5. In the past month, did you experience discomfort or pain during vaginal penetration?	Yes No
6. Is your partner having sexual health issues that you would like to discuss?	Yes No

To the best of my knowledge, this is an accurate statement of my health:

Signature:_____ Date:_____

Provider Comments

Initials: Date:

Provider:_____ **Date:**_____-_____-_____

Patient:_____ **DOB:**_____-_____-_____ **Age:**_____

California Rehabilitation, Inc.
L. Scott Stoney, M.D.
361 Hospital Road, Suite 425
Newport Beach, CA 92663
(949) 548-4580 / FAX (949) 548-2558

WAIVER FORM

Patient Name:_____ Patient Account #:_____

Patient Date of Birth:_____ Patient SSN #:_____-____-_____

Patient Address:_____
Street, Apt #

_____
City, State Zip Code

I, _____, understand and agree that if my insurance denies the services
(Patient's Name)
provided to me from California Rehabilitation, Inc., I will be held financially responsible for payment of all services rendered.

_____ _____
Signature of Patient of Responsible Party Date

_____
Print Name of Patient of Legal Guardian