REBOUND PHYSICAL THERAPY

Patient Name _____ SS#: _____
Address: _____ DOB: _____
City/State/Zip: _____ Marital Status: S M W D
Email Address: _____ Sex: M F
Home Phone: _____ Cell Phone: _____
Emergency Contact/Phone: _____ Relationship: _____

Referred By: _____ Primary Physician: _____
Follow up appointment scheduled with physician? Yes/No Date: _____
Self-Referral Yes/No Date last seen by physician? _____
Why did you choose Rebound? _____

Insurance Information:
Primary Insurance: _____
Policy Holder Name: _____ DOB: _____ Relationship: _____
Secondary Insurance: _____
Policy Holder Name: _____ DOB: _____ Relationship: _____
Tertiary Insurance: _____
Policy Holder Name: _____ DOB: _____ Relationship: _____
Who is the contact person regarding patient billing? _____ **Phone**: _____

Is the injury caused from an auto or work accident? Yes/No Date of accident: ____/____/_____
Is the injury caused from a fall or other accident? Yes/No Date of accident: ____/____/_____
Please provide a brief description of your accident and where it occurred: _____
_____
_____
_____

By my signature, I am authorizing that: I am giving consent for treatment by Rebound Physical Therapy; I understand that a Physical Therapy diagnosis is not a medical diagnosis by a physician; I am authorizing direct assignment of my rights and benefits for insurance payment to be directed to Rebound Physical Therapy for any professional services rendered; I understand that verification of insurance does not guarantee payment and that I am accepting responsibility for payment of all services received; I understand that policies related to insurance are between the insurance carrier and myself; and I take responsibility for any costs or fees associated by my failure to pay for services provided timely manner. Should my account default to an outside collection agency, I understand that I am responsible for all reasonable and customary fees associated with collection of the debt.

Patient/Representative Signature: _____ **Date**: _____

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I have had the opportunity but have chosen not to receive a copy of Rebound's Privacy Practices.
_____ (initials)
I would like a copy of Rebound's Privacy Practices. _____ (initials)

Appointment Reminder Notice

As a courtesy, you will be provided a calendar of upcoming appointments along with a text reminder. Please note, however, appointments changed with less than 24 hours will not receive this reminder notification. If you prefer not to receive text messages, please alert the front desk.

Permission to Disclose Information to Those Involved in My Care

To comply with HIPAA regulations, please list any person (s) other than your doctor or insurance company that may be in contact with our office regarding your care. If they are not listed, we will not provide any health or financial information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Cancellation and No-Show Policy

Our mission at Rebound is to help you get back to an active and healthy lifestyle. Being consistent with your therapy will bring faster results. If you have upcoming travel plans or conflicts that prevent attending your scheduled appointments, please alert your therapist promptly. Your participation is critical in helping you reach your goals. Please be advised that we utilize a cancellation and no-show policy. A full copy of this policy will be provided for your review. A no show or cancellation with less than 24-hour notice will result in a $40.00 charge to your account. Insurance will not cover this charge. To avoid a charge please reschedule your appointment within the same treatment week.

I understand the policy information above. _____ (initials)

Patient Signature: _____ **Date:** _____

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Patient Name: _____ **Case ID:** _____

Age: _____What are we seeing you for today? _____
Specific date of injury/start of symptoms? (mm/day/year)_____
How did this occur? _____
What medications are you currently taking?

_____

_____

List any surgeries:

_____

_____

Have you had any imaging? Y/N List any: _____

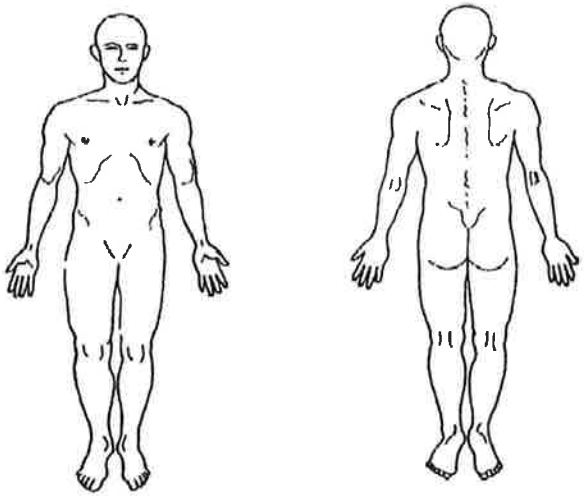
Previous treatment for this same condition? Y/N

List daily activities or goals that you would like to address during your physical therapy sessions:

_____

_____

Employer: _____ Work Phone: _____
Occupation: _____
Describe your pain and mark areas of pain with an "X" and areas of numbness/tingling with "O"



My pain is: ___aching ___burning ___stabbing___ pins and needles ____dull ___sharp __ other: ____

Rank your pain: 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain, 1-2= mild, 3-4= moderate, 5-6= severe, 7-9 = intensely severe 10= emergency room)

Pain worst in morning/ afternoon/ evening? What makes it worse? _____

What eases your pain? _____

Patient Signature: _____ Date:_____

Therapist Signature: _____ Date: _____