BACK IN ACTION

REBOUND PHYSICAL THERAPY

CONTACT INFORMATION:

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 _____

SELF- REFERRAL? YES / NO LAST VISIT WITH PHYSICIAN? _____

WHY DID YOU CHOOSE REBOUND? _____

WHO IS THE CONTACT PERSON REGARDING PATIENT BILLING? _____ PHONE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

POLICY HOLDER NAME: _____ DOB: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____

POLICY HOLDER NAME: _____ DOB: _____ RELATIONSHIP: _____

TERTIARY INSURANCE: _____

POLICY HOLDER NAME: _____ DOB: _____ RELATIONSHIP: _____

INJURY INFORMATION:

IS THE INJURY CAUSED FROM AN AUTO ACCIDENT? YES / NO DATE OF ACCIDENT: ___/___/_____

IS THE INJURY CAUSED FROM A WORK ACCIDENT? YES/ NO DATE OF ACCIDENT: ___/___/_____

IF ANSWER IS YES, 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 IN A 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

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

Please initial by your choice:

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

I would like a copy of Rebound's Privacy Practices. _____(Initial)

Appointment Reminder Notice

As a courtesy, you will be provided a calendar of upcoming appointments along with an automated reminder of your next appointment. Please note that appointments made or changed with less than 24 hours' notice will not receive the reminder notification. Also note: Home phones will be set to receive a voice reminder. Cell phones will receive a text reminder. Should you need to change an appoint, do not respond to the text, but contact our office to reschedule.

Best number for appointment reminder? _____
Is this a home or cell phone? _____

I do not wish to receive a reminder. _____ (initials)

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: _____

Arrival Policy

Our mission at Rebound is to help you get back to an active and healthy lifestyle. Being consistent and committed to your therapy sessions will help you to achieve your desired results. Once the treatment plan is established, any alterations to the scheduled plan of care should be communicated and agreed upon with your evaluating therapist. Also note that symptoms will change as you progress through your three rehab phases: pain reduction, education, and prevention. Please alert your therapist to any symptom changes so adjustments can be made to your treatment or plan frequency. The front desk staff will assist with changing of an appointment time should an unforeseen conflict arise that would otherwise prevent your arrival. If for some reason you do not show or do not contact our office 24 hours in advance of the appointment time, there will be a $40.00 charge for the missed appointment. Insurance does not cover this charge.

I understand the arrival policy information above. _____ (initials)

_____ _____
Patient signature Date