



Patient Information			
Patient Name (Last, First, Middle Initial)		<input type="checkbox"/> Female <input type="checkbox"/> Male	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other
Date of Birth: / /			
Physical Address (No PO Box)	City	State	Zip
			Social Security Number
Mail Address (If Different)	City	State	Zip
			#1 Phone Number <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work ( )
Email Address	Driver's License #		#2 Phone Number <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work ( )
Your Employer (if Self, Please Specify Business)		Business Phone Number ( )	
Occupation			
Employer's Address	City	State	Zip
			Student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Emergency Contact Person	Phone Number: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Other/Work ( )		Relationship to Patient
Financially Responsible (IF PATIENT IS MINOR) (First Last Name)	Relationship to Patient	DOB (Date of Birth)	<input type="checkbox"/> Female <input type="checkbox"/> Male
Address/City/State/ZIP		Phone Number ( )	Cell Phone ( )

Insurance Information			
Primary Insurance	ID Card #(including alpha prefix)	Group #	Effective Date:
Subscriber's name	Date of Birth	Relationship to patient	<input type="checkbox"/> Female <input type="checkbox"/> Male
Secondary Insurance (If Applicable)	ID Card #(including alpha prefix)	Group #	Effective Date:
Subscriber's name	Date of Birth	Relationship to patient	<input type="checkbox"/> Female <input type="checkbox"/> Male
Worker's Comp/Auto Insurance (If Applicable) NOT THIRD PARTY	Company/Adjuster Phone ( )	Adjuster	
Employer at Time of Injury:	Date of Injury:	SSN:	Authorization #:
Attorney's Name (If Applicable)	Address		Attorney Phone ( )
Insured's Name	Date of Birth:	Relationship to Patient:	<input type="checkbox"/> Female <input type="checkbox"/> Male
ID Card or Policy #:	Claim #:	Date of Auto Accident:	

**Consent for Treatment:**

I hereby certify by signing below, that I give Rebound Rehab Physical Therapy, Inc. permission to perform physical therapy treatment services on myself or my child (if applicable, even in the absence of the parent or legal guardian) as appropriately determined by the treating physical therapist and staff. I authorize Rebound Rehab Physical Therapy to communicate with the Referring Physician/ Referring Office and Emergency Contact Person above during the course of my or my child's treatment.

**Assignment of Insurance Benefits:**

I hereby certify by signing below (whether as agent or patient) that all information is true to the best of my knowledge, and I am responsible for all charges incurred for these services. I hereby authorize and assign to Rebound Rehab Physical Therapy any and all benefits arising out of any type of insurance or payer, which insures the patient's bill. The undersigned hereby authorizes Rebound Rehab Physical Therapy to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or Rebound Rehab Physical Therapy for payment of charges to the patient account.

Patient Signature:	Guardian Signature (if Applicable):	Date:
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Patient Name:

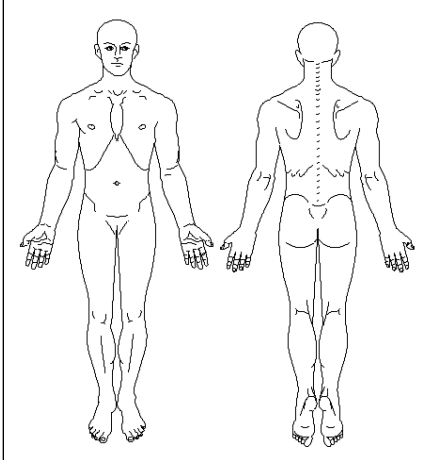
DOB:

Date:

**Injury Information**

Diagnosis (What you're seeing us for):		Onset or Date of Injury:		Is condition surgery related? <input type="checkbox"/> No <input type="checkbox"/> Yes _____		Date of Surgery(s)	
Referring Physician		Address		City	State	Zip	Phone Number ( )
Primary Physician		Address		City	State	Zip	Phone Number ( )
<b>Is condition accident related?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Was an Automobile Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident:		Describe Accident:	
<b>Were you injured on the job?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Injury:		Employer at Time of Injury:		Are You currently working? <input type="checkbox"/> Yes: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> No	
<b>Is litigation involved?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Attorney		Address, City, State and Zip		Attorney Phone ( )	
<b>How did you hear about us?</b> <input type="checkbox"/> My Referring Physician <input type="checkbox"/> My Insurance Company <input type="checkbox"/> A Friend <input type="checkbox"/> Family Member <input type="checkbox"/> Internet <input type="checkbox"/> My Attorney <input type="checkbox"/> Drove by <input type="checkbox"/> Other: _____ Can we thank someone for your referral? _____							

**Current Health History**

General Health Status: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		Current height: _____ Current weight: _____		Recent weight change? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies: Latex <input type="checkbox"/> Yes <input type="checkbox"/> No Adhesives / Tapes <input type="checkbox"/> Yes <input type="checkbox"/> No Other Allergies:				Do you have any implants? (eg Pacemaker, joints, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, Describe:					
Work Status: <input type="checkbox"/> None <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		Occupation:			With Whom Do You Live? <input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent(s) <input type="checkbox"/> Other: _____				
<b>Do you currently have any of the following symptoms?</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Cough <input type="checkbox"/> Hoarseness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Dizziness or Blackouts <input type="checkbox"/> Coordination Problems <input type="checkbox"/> Weakness in arms or legs <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Joint Pain or Swelling <input type="checkbox"/> Bowel/Bladder Problems <input type="checkbox"/> Other:		<b>Has this problem occurred before?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, Describe:			Please mark where you feel current pain  Rate Your Pain (10 being worst): 1 2 3 4 5 6 7 8 9 10				
		<b>Have you had any diagnostic imaging for this problem (i.e. x-rays, MRI, CT)?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, Describe:							
		<b>Do you have hobbies/interests you are unable to perform due to your current diagnosis?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, Describe:							
		<b>Current Medications (list):</b>							

**Past Medical History**

<b>Please check if you have ever had or have been diagnosed with:</b>		
<input type="checkbox"/> Arthritis <input type="checkbox"/> Broken Bones/Fractures <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Blood Disorders _____ <input type="checkbox"/> Circulatory/Vascular Issues <input type="checkbox"/> Heart Problems _____ <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Lung Problems <input type="checkbox"/> Stroke <input type="checkbox"/> Low Blood Sugar/Hypoglycemia <input type="checkbox"/> Head Injury _____ <input type="checkbox"/> Allergies _____	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Diabetes/High Blood Sugar <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Developmental/Growth Issues _____ <input type="checkbox"/> Thyroid Problems _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Infectious Disease _____ <input type="checkbox"/> Kidney Problems _____ <input type="checkbox"/> Repeated Infections _____ <input type="checkbox"/> Ulcers/Stomach Problems _____	<input type="checkbox"/> Skin Diseases _____ <input type="checkbox"/> Depression <input type="checkbox"/> Other _____  <b>Past Surgical History with date(s):</b>



**Patient Name:**

**DOB:**

**Date:**

In the changing insurance environment, costs have become even higher for patients and providers. Regardless of your insurance coverage, your policy is a contract between *you and your insurance carrier*. We strongly suggest you contact your insurance prior to your treatment to verify physical therapy coverage. You are ultimately responsible for payments according to your plan. We have contracts with insurance carriers and have agreed to accept a contracted rate for our services. In addition, we have contractually agreed to bill patients any applicable copays, co-insurance and/or deductible amounts as deemed by the plan. We cannot “discount” these amounts further, so please don’t ask. If your insurance coverage is too costly for you to use, we do offer a Cash Pay option.

**Patient Payment Options** *(Please INITIAL next to the payment option you’re choosing)*

_____ (Initial)	<p><b>Private / Cash Pay – NOT using insurance; I am paying cash, check or credit card at the time of service.</b>          This option is for 1. Patients without insurance. 2. Patients with insurance that doesn’t cover physical therapy. 3. Patients who choose to forego insurance benefits. <b>IF YOU CHOOSE CASH PAY, we will not bill your insurance for services rendered, which includes retro billing. Payment is due at the time of service.</b> If payment is not paid at the time of service, you will be billed a <b>\$15.00</b> administration fee in addition to the treatment charge.          Initial Injury Evaluation: \$100.00. Subsequent treatments for the same diagnosis: \$80.00. These rates are <i>only</i> available at the time of service and are not a “reduction option” for claims that have already been billed to a health insurance.</p>
_____ (Initial)	<p><b>Health Insurance:</b> _____ (your insurance carrier) 2<sup>nd</sup>: _____          We will file your physical therapy claims with your insurance as a courtesy to you. If we are contracted providers with your insurance, we will accept the rate we have agreed to per our insurance contract. We will verify your benefits to the best of our ability with the information given to us. There are no guarantees of benefits. Your insurance processes your claims according to your plan. We require you to assign all insurance payments to our office to avoid misunderstandings.</p> <p><b>We assume no liability for any errors made by your insurance carrier(s) in their quotation of benefits to our office. It is ultimately your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization with your insurance carrier, per your contract with them and inform our office.</b> Any changes or discrepancies must be reported to our office as soon as possible. You are responsible to return inquiries from your insurance company in a timely manner. If claims are denied for any lack of coverage, lack of information, benefit limitation, or are non-covered service(s), you will be responsible for the full balance on your account.</p> <p><u>We require payment at the time of service for copays, no exceptions.</u> For your convenience, you can leave a credit card on file to avoid a <b>\$5.00</b> administrative billing fee for copays not paid at the time of service. To avoid lump sum bills during the billing cycle, we encourage you to pay a portion of your deductible and/or co-insurance at the time of service, which will be applied to the balance of your account. You are responsible for any amounts due per your insurance plan. Should there be a refund, we will refund you during our regular patient billing cycle. <b>We will NOT retro-retract insurance claims for patients who later decide to utilize our Cash Pay rate.</b></p>
_____ (Initial)	<p><b>Medicare</b> You must have progress report every 30 days, or 10 visits (whichever is shorter) while attending physical therapy. Your physician also needs to re-certify you for therapy every 90 days or by the end of your initial prescription. You are responsible for the \$166 Medicare deductible for 2016 and any applicable copayments or coinsurance after your secondary insurance company pays; or if you don’t have a secondary insurance, the full 20% not covered by Medicare. <b>We are not contracted with Medi-Cal, therefore if you have Medi-Cal as your secondary, you are responsible for the 20% of Medicare allowed charges at the time of service.</b></p>
_____ (Initial)	<p><b>Worker’s Compensation</b> Benefits are limited to a number of visits per year, which we have no control over. As a courtesy, we will call your adjuster to get authorization for treatments. Occasionally, additional information is required from you or treating physician and we may ask you to call your adjuster, attorney (if applicable), or physician to assist in requesting this information to avoid delaying physical therapy treatment and progress. <i>You are aware that not attending scheduled sessions may be jeopardizing progress and may also adversely affect your disability status (if applicable).</i></p>
_____ (Initial)	<p><b>Auto MedPay</b> This option is for patients with MedPay benefits on the <b>patient’s own auto insurance policy. We do not accept third-party auto insurance.</b> We must have private health insurance information on file that will be billed for treatment in the event MedPay is exhausted. The patient is responsible for any copay, co-insurance, and/or deductible dictated by insurance. The account balance will not be carried on lien terms and must be settled.</p>
_____ (Initial)	<p><b>Attorney Lien</b> Attorney liens will be accepted on a case-by-case basis. A completed lien form must be on file with all applicable signatures and information at the start of treatment. Attorney and patient must fully comply with our lien terms in order for us to accept a lien. Liens will NOT be accepted in conjunction with another Patient Payment Option.</p>



Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

**Financial Policies**

_____ (Initial)	Payment is due at the time services are rendered, including all supplies, Cash Pay charges, copays, deductible and projected co-insurance portions. <b>To avoid administrative billing fees</b> as stated in the Patient Payment Options, all Cash Pay charges, copays and supplies must be paid for at the time of service.
_____ (Initial)	After an insurance company and/or other payer(s) have paid their portion or finalized your claim(s), should your patient balance be unpaid after 90 days (unless other written financial arrangements have been made), the account can be turned over to an outside collection agency. A collection fee of 30% of the balance will be added to the account and then turned over to collections. You are responsible for any costs associated with collection of your balance, including any legal or court fees.
_____ (Initial)	Should my insurance company send payments to me, I will forward the payment to RRPT within 48 hours. I agree that if I fail to send the payment to RRPT and they are forced to proceed with the collection process of billing me, I will be responsible for any cost incurred to retrieve the monies.
_____ (Initial)	Our billing cycle allows 30 days for remittance on accounts. Late or incomplete balance payments may be subject to a <b>finance charge of \$25.00</b> .
_____ (Initial)	If a check is returned for insufficient funds, you will be responsible for a <b>\$50.00 returned check fee</b> , in addition to the amount of the check.
_____ (Initial)	Patients who have a previous outstanding balance and wish to receive additional services are required to pay all previous balances in full prior to the new course of treatment.
_____ (Initial)	Our medical records are electronic. There is a \$25.00 fee for paper records and a \$20.00 fee for records to be set up for electronic, secure access.
_____ (Initial)	<b>Payment Arrangements for Insurance Patients:</b> Information supplied by your insurance. Deductible: \$_____ has / has not been met. \$_____ payment at each visit towards account balance Co-insurance is: _____ % after the deductible. \$_____ payment at each visit towards account balance Co-Pay is: \$_____ payment at each visit. We accept cash, check, Visa, MasterCard and Discover.

**Appointment Policies**

We pride ourselves on quality, one-on-one treatment for our patients. Cancelled or missed appointments are one the biggest obstacles in returning you to your prior level of function, and without sufficient notice of an anticipated cancellation, we are unable to fill your time slot for another deserving patient.	
_____ (Initial)	I understand that physical therapy is an ongoing process that requires regular attendance and home compliance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may jeopardize my progress and also may adversely affect my disability status (if applicable).
_____ (Initial)	We require 24-hour notice for cancellations, and reserve the right to charge a fee of <b>\$40.00</b> when a patient has violated this policy, which is due at the time of the next appointment.
_____ (Initial)	Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation at the therapist's discretion, in which case, a fee of <b>\$25.00</b> will be applied to your account and due immediately.
_____ (Initial)	It is your responsibility to show up on time for your appointment we have reserved for you. Failure to show up for an appointment will result in a <b>\$60.00 no-show fee</b> that you will be responsible for. This fee is not covered or billable to any insurance or other payer.
_____ (Initial)	Failure to keep 2 consecutive appointments, no shows and accounts no longer maintained in good faith status, may result in termination of the provider-patient relationship with Rebound Rehab Physical Therapy.

I have read, understand and agree to abide by the policies and provision set forth by Rebound Rehab Physical Therapy on this Financial and Appointment Policies form.

Patient Signature: _____	Guardian Signature (if Applicable): _____	Date: _____
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Patient Name:

DOB:

Date:

**Release of Medical Information**

I, \_\_\_\_\_, authorize Rebound Rehab Physical Therapy (includes all employees representing Rebound) to discuss and release all medical information to people named below. This includes information about appointments and scheduling, medical records, x-rays, history, findings and prognosis pertaining to the medical condition, services rendered or treatment given to me. This authorization complies with the Confidentiality of Medical Information Act, Section 56.

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Patient Signature:	Guardian Signature (if Applicable):	Date:
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**Authorization for Email Appointment Reminders**

I, \_\_\_\_\_, authorize Rebound Rehab Physical Therapy to send Appointment Reminders electronically via email to the following email address. Cancellation of the email service must be in writing.

Email Address:	Signature:	Date:
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**Authorization for Text Message Appointment Reminders**

I, \_\_\_\_\_, authorize Rebound Rehab Physical Therapy to send Appointment Reminders electronically via text messaging to the following mobile phone number. I understand this service is offered free of charge, however standard text messaging rates from my mobile carrier may apply that I am solely responsible for. Please activate text message reminders for the following patient/mobile phone number. Cancellation of the text messaging service must be in writing.

Mobile Phone Number:	Mobile Carrier:
Patient Signature:	Date:

**Authorization for Communication**

By my signature below, I authorize Rebound Rehab Physical Therapy personnel to communications by mail, answering machine message and/or email according to the information I have provided in my patient registration information form.

By my signature below, I authorize Rebound Rehab Physical Therapy to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance company(ies), third-party payers, and/or other physicians or healthcare entities in my registration information required to participate in my care.

Patient Signature:	Date:
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## SUMMARY NOTICE OF PRIVACY PRACTICES

( Effective April 14, 2003 )

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### USES AND DISCLOSURE OF YOUR MEDICAL INFORMATION

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or oversight programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. **For Law Enforcement:** We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

### YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

**YOUR RIGHT TO INSPECT AND COPY:** To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request.** **Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice, and will post the current notice in our facility.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

**OTHER USES OF MEDICAL INFORMATION:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Summary Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Personal Representative/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name Printed