Rebound Sports and Orthopedic Physical Therapy

Patient Medical History

Name: _____ Social Security #:_____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: (circle one) **M** **F** Email: _____

Phone: (H) _____ (W)_____ (C)_____

Referring Physician: _____ Office Location:_____

Type of Injury: _____ Date of Injury: _____

Employer: _____ Occupation:_____

Have you ever had any other treatment for this condition? _____

_____

When is your next doctor's appointment scheduled? _____

Are you currently working? Yes / No If no, last date of work _____

Please list any medications you are currently taking: (including dosage) _____

Previous Surgeries & Dates: _____

Do you have an attorney for this injury? (circle one) Yes No

Have you received physical therapy, occupational therapy, or chiropractic services in the past year? (circle one) Yes No

Have you had home health care prior to physical therapy?(circle one) Yes No

May messages be left on your home phone? (circle one) Yes No

Do you now, or have you ever had any of the following conditions:

_____ Diabetes	_____ Heart Disease	_____ Dizziness
_____ High Blood Pressure	_____ Heart Attack	_____ Seizures
_____ Pacemaker	_____ Heart Murmur	_____ Cancer
_____ Kidney Problems	_____ Nervous Disorders	_____ Hernia
_____ Allergies to Heat	_____ Allergies to Ice	_____ HIV Positive
_____ Metal Implants	_____ Pregnant (currently)	_____ Epilepsy
_____ Breathing Difficulties	_____ Muscular Dystrophy	_____ Gout
_____ Rheumatoid Arthritis	_____ Multiple Sclerosis	_____ Fainting
_____ Hearing Loss	_____ Poor Eyesight	_____ Polio
_____ Migraine Headaches		

Other: _____

Insurance Information

Insurance Carrier: _____ ID #: _____

Insurance Policy Holder: _____ DOB: _____

Please fill in this section if you injury is Work Related/Auto Related

Insurance Carrier: _____ WCB#: _____

Address: _____ Claim #: _____

Case Manager: _____ Phone #: _____

Patient Name:_____ Acct #:_____

General Request for Service, Release of Information, Personal Effects & Financial Authorization

I. I hereby voluntarily consent to such evaluation procedures and therapy and to such medical and diagnostic tests, as is necessary in the judgment of the Physical Therapist. I state that I have read and understand the following authorization.

II. I hereby release Rebound Physical Therapy from all liability resulting from loss or damage to any personal effects retained by me on arrival or received by me. This includes, but not limited to, jewelry, eyeglasses, electrical devices, clothing and any other personal item(s).

III. I certify that the information I have provided is correct. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

IV. I understand and agree that I am financially responsible and liable for payment of all charges assessed to me for the professional services rendered by Rebound Physical Therapy. I understand that I am ultimately responsible for all changes regardless of my exiting medical coverage. In the event that my insurance company forwards payments for physical therapy services to me, I will deliver such payment to Rebound Physical Therapy. *NOTICE OF ADVICE:* The notice of advice advises the patient that the treatment may not be covered by their specific health care plan or insurer without a referral. **COPAY_____**

V. I understand and agree that if it becomes necessary for Rebound Physical Therapy to commence any legal action or to obtain an attorney for collection of any outstanding balances on my account, I will be responsible for all reasonable fees incurred by Rebound Physical Therapy, in addition to the outstanding balance due.

VI. I agree to allow Rebound Physical Therapy to obtain any necessary medical history that will benefit my treatment outcome.

I have been offered the HIPAA information as provided by Rebound Physical Therapy.

I have read the above certifications, or they have been read to me and I fully understand them.

I have been provided with a copy of this document to retain for my future reference. (Please initial if you would like a copy)_____

Patient Name:_____

Patient/Guardian Signature_____ Date _____

Other than myself, the following person/s is/are allowed to obtain medical information regarding my medical care: including treatment, progress and appointment schedule.

Name and phone number of Person/s Allowed to obtain My Medical Information/Emergency Contact

_____

_____

_____

_____ _____ _____

Patient's Name Printed | Patient/Guardian Signature | Date

How you heard about Rebound Physical Therapy: (check any that apply)

( ) Doctor's Recommendation
( ) Friend's Recommendation
( ) Advertisement
( ) Prior Injury Treated Here
( ) Other

Rebound Sports and Orthopedic Physical Therapy

POLICY ON SCHEDULED APPOINTMENTS

Dear Patient:

This is to inform you of Rebound Physical Therapy's policy regarding keeping scheduled appointments. Due to treatment schedule, you must notify us 24 hours before your scheduled appointment if you are unable to attend your therapy session. Should you fail to contact us, we reserve the right to personally bill you **$25.00** for you appointments missed.

Please sign below indicating you have been informed of our policy.

We thank you for your cooperation in this manner.

*__PLEASE NOTE__: If you are being treated under Worker's Compensation or No Fault, failure to attend Physical Therapy appointments may be viewed, by the carrier, as being non-compliant and may be considered grounds for a reduction in allowed benefits.

Patient/Guardian Signature_____

Date_____

Patient Name:_____ Acct#:_____