Rebound Physical Therapy - Westborough
Patient Intake Form

---

***Patient Information***

| | |
|---|---|
| **Last Name:** | **SS# (only Worker's Comp):** |
| **First Name:** | **Gender:** |
| **DOB:** | **Home Phone:** |
| **Address:** | **Cell Phone:** |
| **City:** | **Work Phone:** |
| **State: Zip:** | **Email:** |

***Emergency Contact***

| | |
|---|---|
| **Last Name:** | **Relationship:** |
| **First Name:** | **Phone Number:** |

---

## Statement of Previous PT/OT Services:

☐ I **have not** had any previous Physical/Occupational Therapy this calendar/contract year.

☐ I **have** had previous Physical/Occupational Therapy this calendar/contract year. I understand that this may affect my current insurance benefit and I am aware that if services are not covered I will be held accountable for all services rendered.

**Place of Service:**____________________________ **Visits used at facility**:__________________

**Signature of Patient or Guardian:** ___________________________________ **Date:** ____/____/_______

**MEDICARE ONLY**- Home Health Restriction Policy:

☐ I have MEDICARE and understand that I CANNOT UNDER ANY CIRCUMSTANCES utilize Home Health Services related or unrelated to Physical/Occupational Therapy while attending Rebound Physical Therapy; If I do, I will be held accountable for ALL services rendered at Rebound Physical Therapy.

**Signature of Patient or Guardian:** ___________________________________ **Date:** ____/____/_______

## Patient or Guardian Agreement to Payment Policies:

☐ I authorize release of information requested by my insurance plan for payment.

☐ I understand that I am responsible for any balance due based on contractual agreement with my insurance company and that failure to pay any patient balance owed in a timely manner will result in a late payment charge of $5.00 for every month payment is overdue.

☐ I understand that it is my responsibility to inform Rebound Physical Therapy of any changes with my insurance. Failure to do so could affect claims payments, leaving any charges not covered by insurance my responsibility.

☐ I have read and understand Rebound's Cancellation/No Show Policy and agree to comply with the terms and conditions as is indicated on the Patient Welcome Letter. I understand that if I am continually unable to notify Rebound of necessary cancellations in a timely manner then I will be required to pay an increased fee above and beyond the $50.00 stated on the Welcome Letter.

**Signature of Patient or Guardian:** ___________________________________ **Date:** ____/____/_______

## Notice of Privacy Practices:

☐ I hereby acknowledge that I have have been offered a copy of the HIPAA Notice of Information Practices. I understand that I may ask any questions about the HIPAA Notice of Information Practices at any time.

**Signature of Patient or Guardian:** ___________________________________ **Date:** ____/____/_______