Welcome!

Welcome to Rebound Physical Therapy. We are pleased you have selected us for your physical therapy services. We will bring you back to a healthy functional and recreational level and educate you to manage your symptoms independently. We specialize in manual therapy, medical exercise therapy, sports therapy, and aquatic therapy for the treatment of a variety of injuries including back and neck pain, sprain & strains, sports injuries, headaches, scoliosis, arthritis, post-operative rehabilitation, and repetitive stress injuries for a wide range of patients, from children to adults. If you have any questions or concerns, please feel free to call.

For your convenience, please schedule your appointments two weeks in advance.

We understand you may need to cancel an appointment at times, however, we require 24 hours cancellation notice. Without proper notice, the therapist's time is lost and a fee of $50 will be charged to you (not billable to your insurance). We consider your therapy a priority and hope you will do the same.

As a courtesy to our patients, Rebound will bill your insurance company. If however, your insurance company fails to reimburse us properly or in a timely fashion, you will be responsible to pay the balance of the claim and to resolve the issue with your provider.

For most insurance companies, physical therapy requires a co-payment at the time of service. As office policy, if your insurance benefit includes a deductible or coinsurance we require a portion of this to be paid at the time of service as well. Please call your insurance provider so you are informed of your out-patient PT benefits.

Again, thank you for selecting Rebound Physical Therapy for your PT needs. We look forward to working with you to make your therapy as successful as possible.

Thank you,
Steve Crowell, MSPT, CEAS
President

Rebound Physical Therapy-Natick
Patient Intake Form

Patient Information

Last Name:
First Name:
DOB:
Address:
City:
State: **Zip:**

SS# (only Worker's Comp):
Gender:
Home Phone:
Cell Phone:
Work Phone:
Email:

Emergency Contact

Last Name:
First Name:

Relationship:
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:** ____/____/_____

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:** ____/____/_____

Home Health Restriction Policy

Patient Name_

Complete this form and sign below to acknowledge Rebound Physical Therapy's Home Health Restriction Policy.

I have MEDICARE PART B 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 Home Health Services were utilized prior to initiating care at Rebound Physical Therapy, I will provide the necessary discharge paperwork;

If I initiate Home Health Services after initiating treatment at Rebound Physical Therapy, I will make Rebound Physical Therapy aware of those services and understand I may need to cease services at that time.

Home Health Services include any services that are reimbursed through your MEDICARE PART A benefit, including those unrelated to Physical and Occupational Therapy and those unrelated to the condition I am treating for.

If I do receive Home Health Services, I understand MEDICARE PART B will NOT provide reimbursement to Rebound Physical Therapy, and that I will be held accountable for ALL services rendered at Rebound Physical Therapy.

Signature of Patient or Guardian

Date

Appointment Reminder Consent

Patient Name_____

Complete this form and sign below to give your permission for Rebound Physical Therapy to provide automatic appointment reminder service by email.

☐ Rebound Physical Therapy may send email messages to confirm my upcoming appointments to

Email:_____

_____

Signature of Patient or Guardian

_____

Date

Medical History/ Evaluation

Name: _____ Date of Birth: _____/_____/_____

Is your injury a result of an auto accident claim or a work-related incident claim? Yes / No

Please circle any diagnostic services you had for this injury: X-Ray, MRI, EMG, other: _____

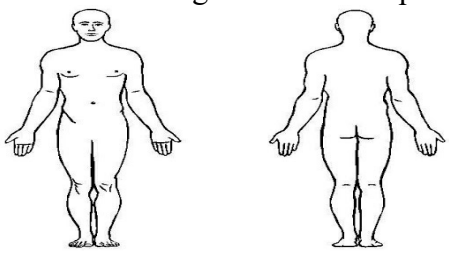
Did you have surgery for this injury? Yes / No Type of Surgery: _____

How has pain changed since onset? _____

Do you now have or have you ever had any of the following?	Yes	No
Asthma, Bronchitis, or Emphysema		
Shortness of Breath/Chest Pain		
Coronary Heart Disease or Angina		
Do you have a pacemaker?		
High Blood Pressure		
Heart Attack/ Surgery		
Stroke/ TIA		
Blood Clot/ Emboli		
Epilepsy/ Seizures		
Thyroid Trouble/ Goiter		
Anemia		
Infectious Disease		
Diabetes		
Cancer or Chemotherapy/ Radiation		
Arthritis/ Swollen Joints		
Osteoporosis		
Gout		
Difficulty Sleeping		
Mental Health Diagnosis		
Bowel or Bladder Issues		
Severe or Frequent Headaches		
Vision or Hearing Difficulties		
Numbness or Tingling		
Dizziness or Faintness		
Hernia		
Varicose Veins		
Weight Loss/Energy Loss		

Additional Information:	Yes	No
Any Pins or Metal Implants		
Joint Replacements		
Neck Injury/Surgery		
Shoulder Injury/Surgery		
Elbow Injury/Surgery		
Back Injury/Surgery		
Knee Injury/Surgery		
Leg/Ankle/Foot Injury/Surgery		
Are you pregnant?		
Allergies: If yes, what?: _____		
Do you smoke? If yes, how much? _____		
Alcohol Consumption? _____ If yes, how much? _____		
List any other information that would assist us in your care:		

Indicate on the diagram where the pain is:



Height: _____feet _____inches Weight: _____ lbs
Have you fallen in the past year?: Yes No If yes, please list number of falls: _____
Are you currently taking any prescription or non-prescription medications? Yes No
- If yes, please attach a list of current medications or list on the back.

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize the release of payment directly to Rebound Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for an additional $25 collections cost incurred. I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature:_____Date:_____

HIPAA NOTICE OF INFORMATION PRACTICES

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

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care of treatments. This information is often referred to as your health or medical records and serves as a:

- Basis of planning your care and treatment
- Means of communication among the health professionals participating in your care
- Legal document describing the care you received
- Means by which you or a third-party payer can certify that the services billed were actually provided
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work on to improve the care we deliver and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, make more informed decisions when authorizing disclosure to others; and better understand who, what, when, where and why others may access your health information.

Understanding your Health Information Rights

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your Information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations

We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you the next time you come to our office for treatment.

If you have questions and would like additional information, you may contact our Privacy Officer at 781-237-1769. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

(see other side)

Examples of Disclosures for Treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example, information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way, your physicians and other providers will know how you are responding to treatment. Copies of these records, as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with Worker's Compensation or other similar programs established by law.

We will use your health information for regular health operations. For example, members of our quality improvement team may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used to continually improve the quality and effectiveness of the healthcare and services we provide.

Business Associates. There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.

Family communication. After careful judgement, we may disclose to a family member or other person you designate, health information relevant to that person's involvement in your care or payment related to your care.

Funeral directors & organ procurement organizations. We may disclose health information to funeral directors consistent with applicable law. We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health. As required by law, we may disclose health information to the public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement and Correctional Institution. We may disclose health information for law enforcement purposes as required by law. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.