Rebound Physical Therapy
Patient Intake Form

Patient Information

Last Name: **SS#:**
First Name: **Gender:**
DOB: **Home Phone:**
Address: **Cell Phone:**
City: **Work Phone:**
State: **Zip:** **Email:**

Emergency Contact

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

Consent For Treatment:

I hereby consent to, and authorize my physical therapist who may be involved in my care, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist or other healthcare professionals. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that it is my responsibility to inform my physical therapist or other health care professional if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that response to physical therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Signature of Patient or Guardian: _____ **Date:** ____/____/_____

Attendance Policy:

I understand I may be charged a cancellation or no-show fee of $50 for missed visits if I do not provide notice at least 24 hours in advance. I understand if 3 no-shows occur, I may be discharged from physical therapy prior to completion of the plan of care.

Signature of Patient or Guardian: _____ **Date:** ____/____/_____

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:** ____/____/_____

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:** ____/____/_____

Appointment Reminder Consent

Date:

Name:

Complete this form and sign below to give your permission for Rebound Physical Therapy to provide automatic appointment reminders by email or by cell phone text message.

Select <u>ONE</u> Option Below

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

_____

☐ Rebound Physical Therapy may send cell phone text messages to confirm my upcoming appointments to

_____

I recognize that normal text messaging rates may apply.

We cannot set your account up to send text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

☐	ALLTel	☐	MetroPCS
☐	AT&T	☐	Nextel
☐	Boost Mobile	☐	QWest
☐	Cingular	☐	T-Mobile
☐	Cricket Wireless	☐	Verizon
☐	Metrocall	☐	Xfinity

If your carrier is not listed we are unable to provide text reminders at this time.

☐ I decline appointment reminders at this time.

_____

Signature of Patient or Guardian

_____

Date

Medical History/ Evaluation

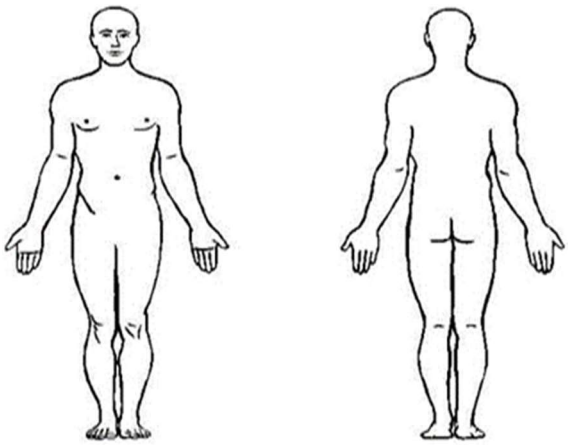
Name: _____ Date of Birth: _____
Gender: M / F Height: _____ Weight: _____
Personal Pronouns (Please Circle): he/him/his, she/her/hers, they/them/theirs
Have you had any falls in the past year? Yes / No
Is your injury a result of an auto accident claim or a work-related incident claim? Yes / No
Please circle any diagnostic services you've had: X-Ray, MRI, EMG, other: _____
Did you have surgery for this injury? Yes / No Type of Surgery: _____

PLEASE PROVIDE A LIST OF MEDICATIONS TO BE SCANNED OR WRITE ON THE BACK.

Please Check All That Apply:	
Asthma, Bronchitis, or Emphysema	
Shortness of Breath/Chest Pain	
Coronary Heart Disease or Angina	
Pacemaker	
Atrial Fibrillation	
High Blood Pressure	
Heart Attack/ Surgery	
Stroke/ TIA	
Blood Clot/ Emboli	
Concussion	
Neurological Diagnosis _____	
Hyper/ Hypo Thyroid	
Anemia	
Infectious Disease _____	
Diabetes	
Cancer or Chemotherapy/ Radiation	
Arthritis	
Osteoporosis	
Gout	
Hernia	
Difficulty Sleeping	
Mental Health Diagnosis	
Severe or Frequent Headaches	
Double Vision	
Deaf	
Hard of Hearing	
Numbness or Tingling	
Dizziness or Faintness	
Bowel or Bladder Issues	
Significant Change in Balance	
Weight Loss/Energy Loss	
Hemochromatosis	

Additional Information:	
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?	
Do you smoke?	
Alcohol Consumption? If yes, how much?	
Allergies:	
Any other information that would assist us in your care:	

Where is your pain?



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:_____

Financial Agreement with Rebound Physical Therapy

Rebound Physical Therapy is devoted to providing you with the best possible care. If you have health insurance, we are committed to helping you receive the maximum allowable benefits. We must emphasize that as health care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to all our clients; all charges are your responsibility from the date the services were provided. Your financial agreement with Rebound Physical Therapy is below:

I understand that I am financially responsible for any services **not** covered or allowed, and not paid due to the terms of my insurance coverage. I understand that it is my responsibility to comply with the guidelines set by my insurance company, and if applicable, I have an obligation to obtain a referral for specialist services from my PCP **prior** to having services rendered. I acknowledge that if the appropriate referral/authorization is not on file at the time services are rendered, that I am financially responsible for any charges denied by my health insurance carrier as a result.

I understand that all copays are due at the time of service. I understand that balances from processed claims (i.e., patient responsibility from deductible, coinsurance…) are expected to be paid with the issuance of statement. I understand that if failure to pay balances in a timely manner causes me to carry a balance over $500, I will be subject to having my appointments cancelled and be unable to schedule further appointments until balance is addressed.

I understand that balances aged over 90+ days may be transferred to a collection agency with the inclusion of a $25 fee.

I acknowledge that if the visit is due to a work or auto related injury, it is my responsibility to obtain an authorized claim number from my employer's workers compensation or auto insurance and maintain approval for every visit. I acknowledge that I am responsible for all balances resulting from non-authorized charges.

(continued on next page, signature field required)

203 Oak Street, Natick, MA 07160
P: (508) 651-0051 | **F:** (508) 651-0061

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I acknowledge that a cancellation fee of $50 will be applied to any visit cancelled within 24 hours of the appointment and a no show fee of $50 will be applied to any visit where a patient fails to attend a scheduled visit without notification. I understand that if I fail to comply with the terms of this cancellation and no-show policy, my future appointments may be subject to cancellation and I will be unable to schedule further appointments until balance is addressed.

I hereby assign all benefits directly to Rebound Physical Therapy and authorize payment directly to Rebound Physical Therapy for services rendered otherwise payable to me. I authorize release of any medical records necessary to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

My signature below affirms that I understand this statement and have accepted responsibility for all fees incurred for my medical care.

_____

Name of Patient

_____ _____

Signature of Patient or Guardian if under 18 years old Date

203 Oak Street, Natick, MA 07160
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rebound physical therapy

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.