6526 Lonetree Blvd, Ste. 200
Rocklin, CA 95765
tel. 916.772.2909 | fax 916.772.2989
www.reboundrehabpt.com

## Patient Information

| | | | |
|---|---|---|---|
| **Patient Name (Last, First, Middle Initial)** | ☐ Female ☐ Male | Status: ☐ Single ☐ Married ☐ Widowed ☐ 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 ☐ Mobile ☐ Home ☐ Work ( ) | |
| Email Address | Driver's License # | #2 Phone Number ☐ Mobile ☐ Home ☐ Work ( ) | |
| Your Employer (if Self, Please Specify Business) | Business Phone Number ( ) | Occupation | |
| Employer's Address City State Zip | | Student ☐Full Time ☐ Part Time | |
| **Emergency Contact Person** | Phone Number: ☐ Mobile ☐ Home ☐ Other/Work ( ) | Relationship to Patient | |
| **Financially Responsible (IF PATIENT IS MINOR) (First Last Name)** | Relationship to Patient | DOB (Date of Birth) | ☐ Female ☐ 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 | ☐ Female ☐ Male |
| **Secondary Insurance (If Applicable)** | ID Card #(including alpha prefix) | Group # | Effective Date: |
| Subscriber's name | Date of Birth | Relationship to patient | ☐ Female ☐ 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: | ☐ Female ☐ 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: |
|---|---|---|
| | | |

REBOUND Rehab Physical Therapy

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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? □ No □ Yes _____ | Date of Surgery(s) |
|---|---|---|---|

| **Referring Physician** | Address | City | State | Zip | Phone Number ( ) |
|---|---|---|---|---|---|
| Primary Physician | Address | City | State | Zip | Phone Number ( ) |

| **Is condition accident related?** □ Yes □ No | Was an Automobile Involved? □ Yes □ No | Date of Accident: | Describe Accident: |
|---|---|---|---|

| **Were you injured on the job?** □ Yes □ No | Date of Injury: | Employer at Time of Injury: | Are You currently working? □ Yes: □ Full-time □ Part-Time □ No |
|---|---|---|---|

| **Is litigation involved?** □ Yes □ No | Name of Attorney | Address, City, State and Zip | Attorney Phone ( ) |
|---|---|---|---|

**How did you hear about us?** □ My Referring Physician □ My Insurance Company □ A Friend □ Family Member □ Internet □ My Attorney
□ Drove by □ Other: _____ Can we thank someone for your referral?_____

## Current Health History

| General Health Status: □ Excellent □ Good □ Fair □ Poor | Current height: _____ Current weight:_____ | Recent weight change? □ Yes □ No | Do you smoke? □ Yes □ No | Are you pregnant? □ Yes □ No |
|---|---|---|---|---|

| Allergies: Latex □ Yes □ No Adhesives / Tapes □ Yes □ No Other Allergies: | Do you have any implants? (eg Pacemaker, joints, etc.) □ No □ Yes, Describe: |
|---|---|

| Work Status: □ None □ Full-time □ Part-time | Occupation: | With Whom Do You Live? □ Alone □ Spouse □ Child □ Parent(s) □ Other: _____ |
|---|---|---|

**Do you currently have any of the following symptoms?**
□ Chest Pain
□ Heart Palpitations
□ Cough
□ Hoarseness
□ Shortness of Breath
□ Dizziness or Blackouts
□ Coordination Problems
□ Weakness in arms or legs
□ Loss of Balance
□ Difficulty Walking
□ Joint Pain or Swelling
□ Bowel/Bladder Problems
□ Other:

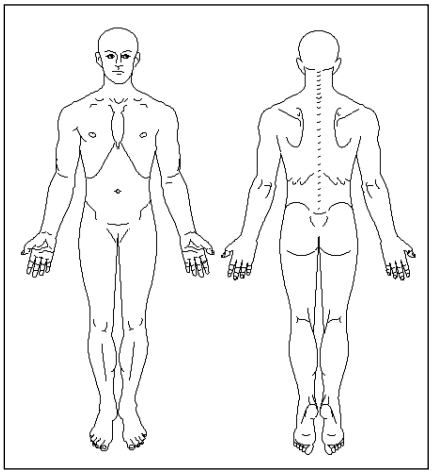
**Has this problem occurred before?**
□ No □ Yes, Describe:

**Have you had any diagnostic imaging for this problem (i.e. x-rays, MRI, CT?** □ No □ Yes, Describe:

**Do you have hobbies/interests you are unable to perform due to your current diagnosis?**
□ No □ Yes, Describe:

**Current Medications (list):**

Please mark where you feel current pain



Rate Your Pain (10 being worst):
1 2 3 4 5 6 7 8 9 10

## Past Medical History

**Please check if you have ever had or have been diagnosed with:**

□ Arthritis
□ Broken Bones/Fractures
□ Osteoporosis
□ Blood Disorders_____
□ Circulatory/Vascular Issues
□ Heart Problems _____
□ High Blood Pressure
□ Lung Problems
□ Stroke
□ Low Blood Sugar/Hypoglycemia
□ Head Injury _____
□ Allergies _____

□ Multiple Sclerosis
□ Diabetes/High Blood Sugar
□ Muscular Dystrophy
□ Parkinson's Disease
□ Seizures/Epilepsy
□ Developmental/Growth Issues_____
□ Thyroid Problems _____
□ Cancer _____
□ Infectious Disease _____
□ Kidney Problems _____
□ Repeated Infections _____
□ Ulcers/Stomach Problems _____

□ Skin Diseases _____
□ Depression
□ Other _____

**Past Surgical History with date(s):**

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**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 per our contracts.

| **Patient Payment Options** *(Please INITIAL next to the payment option you're choosing)* | |
|---|---|
| _____ (Initial) | **GOOD FAITH ESTIMATE: Uninsured / Cash Pay – *NOT using insurance*** 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. IF YOU CHOOSE CASH PAY, we will not bill insurance for services rendered, which includes retro billing. **Payment is due at the time of service.** If payment is not paid at the time of service, you can be billed a **$15.00** administration fee in addition to the treatment charge. Initial Injury Evaluation: $120.00. Subsequent treatments for the same diagnosis: $100.00. These rates are *only* available at the time of service and are not a "reduction option" for claims that have already been billed to a health insurance. |
| _____ (Initial) | **Health Insurance:** _____ (your insurance carrier) 2nd:_____ 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.<br><br>**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.** 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.<br><br>We require payment at the time of service for copays, no exceptions. There is a **$5.00** 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 cycle. **We CANNOT retro-retract insurance claims for patients who later decide to utilize our Cash Pay rate.** |
| _____ (Initial) | **Medicare** 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. You are responsible for the $240.00 Medicare deductible for 2024 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. ***We are not contracted with Medi-Cal or MediCaid, therefore if you have either as your secondary, you are responsible for the amount deemed your responsibility per any EOBs. QMB excepted.*** |
| _____ (Initial) | **Worker's Compensation** Benefits are limited to a number of visits per year. **Physical therapy visit requests must be made by the referring physician's office**. 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. *You are aware that not attending scheduled sessions may be jeopardizing progress and may also adversely affect your disability status (if applicable).* |
| _____ (Initial) | **Auto MedPay** This option is for patients with MedPay benefits on the **patient's own auto insurance policy. We do not accept third-party auto insurance.** 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. |
| _____ (Initial) | **Attorney Lien** 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 health insurance Payment Option. |

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**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. To avoid administrative billing fees as stated in the Patient Payment Options, all Cash Pay charges, copays and supplies must be paid for at the time of service.<br><br>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) | 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.<br><br>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 billing cycle allows 30 days for remittance on accounts. Late or incomplete balance payments may be subject to a **finance charge of $10.00**. If a check is returned for insufficient funds, you will be responsible for a **$50.00 returned check fee.** |
| _____ (Initial) | Our medical records are electronic and we're happy to give the patient access through our secure document portal. There is a minimum $25.00 fee for paper records (additional rates apply for large charts at $0.25/page) and a $20.00 fee for records to be set up for electronic facsimile transmission for third-party requests. |
| _____ | **Payment Arrangements for Insurance Patients:** Information supplied by your insurance.<br>Deductible: $_____ has / has not been met. $_____ payment at each visit towards account balance<br>Co-insurance is: _____ % after the deductible. $_____ payment at each visit towards account balance<br>Co-Pay is: $_____ payment at each visit. |

| 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).<br><br>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. |
| _____ (Initial) | We require 24-hour notice for cancellations, and reserve the right to charge a fee of **$40.00** (due at the time of the next appointment) when a patient has violated this policy. We do understand there are circumstances that can't be avoided and reserve the right to waive the fee at our discretion.<br><br>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 **$25.00** can be applied to your account and due immediately.<br><br>Failure to show up for an appointment can result in a **$60.00 no-show fee** that you will be responsible for. |

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: |
|---|---|---|
| | | |

Rev 1/1/2024

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## 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: |

## 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: |

## 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 text notifications, 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

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.
(Effective April 14, 2003)

## USES AND DISCLOSER 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 similar 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** |
|---|---|---|