



Patient Registration Form

<input type="checkbox"/> New Patient <input type="checkbox"/> Returning <input type="checkbox"/> New Diagnosis <input type="checkbox"/> New Insurance					
Patient Name (Last, First, Middle Initial)			Patient DOB (Date of Birth)		Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address			City/State/Zip		
Home Phone ()		Work Phone ()		Cell Phone ()	
Social Security #		Driver's License #		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other	
Employer		Address		City/State/Zip	
Emergency Contact Person		Phone Number ()		Cell Phone Number ()	
Referring Physician			UPIN		NPI
Address/City/State/ZIP			Phone Number ()		Fax Number ()
Primary Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Group Insurance <input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other _____ PTPN <input type="checkbox"/> Yes <input type="checkbox"/> No			Secondary insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Group Insurance <input type="checkbox"/> Other _____ PTPN <input type="checkbox"/> Yes <input type="checkbox"/> No		
Financially Responsible (Other Than Patient) Name (First,Last)			Relationship to Patient		DOB (Date of Birth)
Address/City/State/ZIP			Phone Number ()		Cell Phone ()

Injury Information

Diagnosis (What you're seeing us for):			Date of Injury or Surgery:		ICD9(s): (FOR OFFICE USE)
Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Surgery(s)		Surgical Procedure(s)	
Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was an Automobile Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Accident	Describe Accident
Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Injury		Are You currently working? <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> No	
Name of employer at time of accident		Address, City, State, and Zip			Phone Number ()
Is litigation involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Attorney		Address, City, State and Zip	
					Phone number ()

How did you hear about us? My referring physician My insurance company A Friend Family Member Internet
 Phone Book Drove by Other: _____

Can we thank someone for your referral? _____

I hereby certify that all information is true to the best of my knowledge, and I am responsible for all charges incurred for these services. I hereby give Rebound Rehab Physical Therapy, Inc. permission to perform physical therapy services on myself or my child (if applicable, even in the absence of the parent or legal guardian) as appropriately determined by the physical therapist.

Patient Signature:	Date:
Guardian Signature (if patient is under 18):	Date:



Insurance Information

Primary Insurance		Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year	Visits remaining
Subscriber's name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to patient
ID Card #(including alpha prefix)	Group #	Claim #		
Claims Mailing Address		City, State, Zip Code		Provider Service Phone # ()

Secondary Insurance		Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year	Visits remaining
Subscriber's name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to patient
ID Card #(including alpha prefix)	Group #	Claim #		
Claims Mailing Address		City, State, Zip Code		Provider Service Phone # ()

Worker's Comp Insurance Company:	Comp Company Phone: ()	Claim #	Date of Injury
Employer at the Time of Injury:	Address		Employer Phone ()
Authorization #	Adjuster Name	Adjuster Phone: ()	Adjuster Fax ()
Claims Mailing Address		City, State, Zip Code	

Auto Accident Insurance Company (not third-party):			Insurance Phone Number ()
Insured's Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to patient
ID Card or Policy #:	Claim #:	Date of Accident:	Adjuster's Name:
Claims Mailing Address		City, State, Zip Code	

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and is hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by Rebound Rehab Physical Therapy and assigns to Rebound Rehab Physical Therapy any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. 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.
4. Rebound Rehab PT reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for Rebound Rehab Physical Therapy.

PATIENT NAME (PRINTED): _____

PATIENT SIGNATURE: _____ **DATE:** _____
 (GUARDIAN IF PATIENT IS UNDER 18)

Patient Health History

General Health Status:

- Excellent Good Fair Poor

Current weight: _____
 Recent weight change? Yes No

Are you allergic to:
 Latex Yes No
 Adhesives / Tapes Yes No
 Other: _____

Do you have any implants? (eg
 Pacemaker, joints, etc.) _____

Are you pregnant? Yes No

SOCIAL HISTORY

Work Status:

- Full-time Part-time None

With Whom Do You Live?

- Alone Spouse Child Parent(s)
 Group Setting Other: _____

Living Environment:

Does your home have:
 Stairs Assistive Devices

Social/Health Habits:

Do you smoke? Yes No

Do you exercise beyond normal
 activity/chores? Yes No
 Describe: _____

Do you have any hobbies/interests you
 are unable to perform due to your
 current diagnosis? Yes No
 Describe: _____

SURGICAL HISTORY

Is your visit related to a surgical
 procedure? Yes No _____

Past surgical history _____

Future surgical procedures _____

Medications: _____

MEDICAL HISTORY

Please check if you have ever had:

- Arthritis
- Broken Bones/Fractures
- Osteoporosis
- Blood Disorders _____
- Circulatory/Vascular Issues
- Heart Problems _____
- High Blood Pressure
- Lung Problems
- Stroke
- Diabetes/High Blood Sugar
- Low Blood Sugar/Hypoglycemia
- Head Injury _____
- Allergies _____
- Multiple Sclerosis
- 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 _____

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

History of Current Complaint

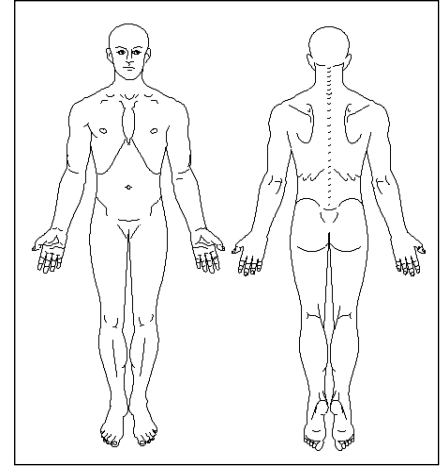
Are you seeing any other health care
 provider for the current problem?
 Yes No _____

Has this problem occurred before?
 Yes No Describe: _____

Have you ever had any diagnostic
 imaging for this problem (i.e. x-rays,
 MRI, CT)? Yes No

PAIN PROFILE

Please mark where you feel pain.



Describe your pain: _____

When did your pain begin?

_____ **Patient name (please print)**

_____ **Patient (or Guardian) Signature**

Date: _____



Appointment Policy

I understand that my doctor has prescribed physical therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress and also my adversely affect my disability status.

CANCELLATION / NO SHOW POLICY:

We pride ourselves on our quality, one-on-one treatment for our patients, so cancelled or missed appointments are one the biggest obstacles in returning you to your prior level of function. Without sufficient notice of an anticipated cancellation, we are unable to fill your time slot with another deserving patient, so **we require 12 hour notice for cancellations, and reserve the right to charge a fee of \$25 when the patient has multiple occurrences.**

LATE APPOINTMENTS:

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation.

I have read and understand the above stipulations and agree to comply with the Appointment Policy.

Patient (or Guardian) Initials: _____

Financial Policy

INSURANCE RESPONSIBILITY:

Any changes in your insurance coverage need to be reported to our office as soon as possible. As a courtesy, we will verify coverage, obtain authorization (if necessary), and bill your insurance company directly for you. Unfortunately, there are no guarantees of benefit reimbursement until claims are received and processed by your insurance. We require you to assign all insurance payments to our office to avoid misunderstandings regarding payments. **If you request your insurance company (or if they require) to pay you directly, we will require full payment when services are rendered.**

We strongly advise you to verify your coverage for outpatient physical therapy with your insurance company. You need to verify your percentage of payment per visit, any copayments, deductibles and limits of visits or dollar amounts per year, as it is ultimately your responsibility for any portion not paid by insurance. **We assume no liability for any errors made by your insurance carrier(s) in their quotation of benefits. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately.**

Worker's Compensation benefits can be limited to a certain number of visits per year, which we have no control over. As a courtesy, we will call your worker's compensation company to obtain authorization for treatments. Occasionally, additional information is required from the patient and we may ask you to call your Adjuster (or your attorney if applicable) to assist in obtaining authorizations. Occasionally, your worker's compensation company will require additional notes or reports from your treating physician, and you may be asked to assist in requesting this information from your physician to avoid delaying physical therapy treatment.

Medicare requires you 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 every 90 days or by the end of your initial prescription. You are responsible for the \$155 Medicare deductible for 2010 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, therefore if you have Medi-Cal as your secondary, you are responsible for those charges after Medicare pays.*

Payment is due at the time services are rendered, including all supplies, cash patient charges and copayments. We encourage patients pay an estimate of coinsurance and/or deductible to his/her account to avoid a lump sum payment at the next patient billing cycle.

If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of the check. After the insurance company has paid their portion of your claim, should your financial responsibility be unpaid after 90 days (unless other financial arrangements have been made), the account can be turned over to a collection agency. Collection agencies typically charge 33% of the unpaid bill. Should these additional costs be incurred, you will be responsible for them in addition to the unpaid balance.

*I understand and agree to comply with the Financial Policy explained above. **Late payments may be subject to a \$10 finance charge.** I hereby authorize the release of any medical information necessary to process my claim and authorize my insurance company to pay Rebound Rehab Physical Therapy, Inc. directly for services rendered. It is understood that by signing below, I am responsible for any or all charges not covered by my insurance company and any charges not paid may be placed for collection. I have read and understood all foregoing statements and contents.*

Printed Name of Patient: _____

Patient (or Guardian) Signature: _____ **Date:** _____



NOTICE OF PRIVACY PRACTICES

(Effective April 14, 2003)

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.

USES AND DISCLOSURE 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 Notice of Privacy Practices.

Patient or Personal Representative/Guardian Signature

Date