Rebound Sports and Orthopedic Physical Therapy

Patient Medical History

Name:	Social Security #:		
Address:	Apt #:		
City:	State: Zip Code:		
Date of Birth: Sex: (circle of	one) M F Email:		
Phone: (H) (W)	(C)		
Referring Physician:	Office Location:		
Type of Injury:	Date of Injury:		
Employer:	Occupation:		
Have you ever had any other treatment fo	r this condition?		
Are you currently working? Yes / No If no	scheduled? o, last date of work ntly taking: (including dosage)		
Previous Surgeries & Dates:			
Do you have an attorney for this injury? (o	circle one) Yes No		
Have you received physical therapy, occup	oational therapy, or chiropractic services in the		
past year? (circle one) Yes No			
Have you had home health care prior to p	hysical therapy? (circle one) Yes No		
May messages be left on your home phone	e? (circle one) Yes No		

Do you now, or have you ever had any of the following conditions:

Diabetes	Heart Disease	Dizziness
High Blood Pressure	Heart Attack	Seizures
Pacemaker	Heart Murmur	Cancer
Kidney Problems	Nervous Disorders	Hernia
Allergies to Heat	Allergies to Ice	HIV Positive
Metal Implants	Pregnant (currently)	Epilepsy
Breathing Difficulties	Muscular Dystrophy	Gout
Rheumatoid Arthritis	Multiple Sclerosis	Fainting
Hearing Loss	Poor Eyesight	Polio
Migraine Headaches	Other:	

I currently have none of the medical problems above: _____

Insurance Information		
Insurance Carrier:	ID #:	
Insurance Policy Holder:		DOB:

Please fill in this section if your injury is Work Related/Auto Related		
Insurance Carrier:	WCB#:	
Address:	Claim #:	
Case Manager:	Phone #:	

<u>General Request for Service, Release of Information, Personal Effects & Financial</u> <u>Authorization</u>

I. I hereby voluntarily consent to such evaluation procedures and therapy and to such medical and diagnostic tests, as is necessary in the judgment of the Physical Therapist. I state that I have read and understand the following authorization.

II. I hereby release Rebound Physical Therapy from all liability resulting from loss or damage to any personal effects retained by me on arrival or received by me. This includes, but not limited to, jewelry, eyeglasses, electrical devices, clothing and any other personal item(s).

III. I certify that the information I have provided is correct. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

IV. I understand and agree that I am financially responsible and liable for payment of all charges assessed to me for the professional services rendered by Rebound Physical Therapy. I understand that I am ultimately responsible for all changes regardless of my exiting medical coverage. In the event that my insurance company forwards payments for physical therapy services to me, I will deliver such payment to Rebound Physical Therapy. *NOTICE OF ADVICE:* The notice of advice advises the patient that the treatment may not be covered by their specific health care plan or insurer without a referral. **COPAY**_____

V. I understand and agree that if it becomes necessary for Rebound Physical Therapy to commence any legal action or to obtain an attorney for collection of any outstanding balances on my account, I will be responsible for all reasonable fees incurred by Rebound Physical Therapy, in addition to the outstanding balance due.

VI. I agree to allow Rebound Physical Therapy to obtain any necessary medical history that will benefit my treatment outcome.

I have been offered the HIPAA information as provided by Rebound Physical Therapy.

I have read the above certifications, or they have been read to me and I fully understand them.

I have been provided with a copy of this document to retain for my future reference. (Please initial if you would like a copy)_____

Patient Name:

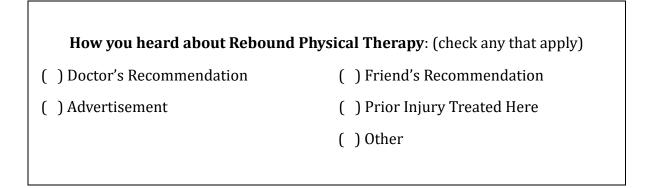
Other than myself, the following person/s is/are allowed to obtain medical information regarding my medical care: including treatment, progress and appointment schedule.

Name and phone number of Person/s Allowed to obtain My Medical Information/Emergency Contact

Patient's Name Printed

Patient/Guardian Signature

Date



Rebound Sports and Orthopedic Physical Therapy

POLICY ON SCHEDULED APPOINTMENTS

Dear Patient:

This is to inform you of Rebound Physical Therapy's policy regarding keeping scheduled appointments. Due to treatment scheduling, you must notify us 24 hours before your scheduled appointment if you are unable to attend your therapy session. Should you fail to contact us, we reserve the right to personally bill you **\$50.00** for your appointments missed.

Please sign below indicating you have been informed of our policy.

We thank you for your cooperation in this manner.

***PLEASE NOTE**: If you are being treated under Worker's Compensation or No Fault, failure to attend Physical Therapy appointments may be viewed, by the carrier, as being non-compliant and may be considered grounds for a reduction in allowed benefits.

Patient/Guardian Signature	
Date	

Patient Name:	Acct#:	