Dear Physical Therapy Patient,

Sports & Physical Therapy

Welcome to Rebound Sports & Physical Therapy! We are happy you chose us to assist with your care. We strive towards providing an excellent experience for all our patients as we assist you in regaining your active lifestyle. Here is an outline of some things to expect during your visits to our clinic:

Initial Visit – Your physical therapy evaluation:
Your physical therapist will take a thorough medical history as well as take appropriate measurements and perform physical therapy diagnostic tests as part of the examination. Your therapist will provide you with helpful information regarding your condition and outline a treatment plan so you know what to expect during future appointments. Please bring comfortable clothing that is easy to move around in to this appointment. An initial examination lasts approximately 60 minutes.

Follow-up visits and treatment:
At Rebound, you will always work with the same physical therapist that performed your initial evaluation unless you agree to or want a different therapist. We want what is best for you! All of our physical therapists are licensed by the state of Colorado and are trained in the latest methods in biomechanics, functional recovery, and pain relief. Follow-up visits usually last around 30 minutes, but may extend up to 45 minutes depending on your situation.

Arriving for your appointments:
Please check in with our front desk staff. They are ready to assist you with any scheduling questions you may have. Once they check you in, your physical therapist is alerted that you are in the clinic. If you expect to be late for your appointment, kindly call our office as we may have to reschedule you.

Checking out from your appointments:
Please stop and check out with our front desk staff. They will collect any payment for service per your insurance plan (see financial information below.) They will also go over your future scheduled appointments with you to assure that your calendar and our calendar match.

Financial Information:
Payment for service is expected at each visit. Insurance plans differ greatly, but most plans have a copayment, co-insurance, or deductible amount that needs to be paid when physical therapy services are rendered. Ultimately, it is your responsibility to understand your coverage and we encourage you to contact your insurance company's customer service department with any questions you have. We offer self-pay rates if not going through insurance. Please ask our front desk staff for more information if you have questions. If you anticipate difficulty in paying, please call our billing department so they can come up with an agreeable payment plan for you.

Medicare Patients:
If you have Medicare, there are some additional guidelines that apply to you for Medicare to cover physical therapy services. These are as follows:

- Medicare requires you to be under the care of a physician. Our clinic requires a written referral from your physician to treat you. Your doctor will receive a plan of care after the initial evaluation which must be approved. Periodically a new plan of care will be forwarded to your physician by your therapist should you need further rehabilitation services.
- Medicare does not cover outpatient physical therapy in conjunction with homecare services.

Once again, thank you for choosing Rebound Sports & Physical Therapy for your rehabilitation needs. We look forward to meeting you!

PATIENT SUMMARY

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Date: _____

PERSONAL INFORMATION

Legal Name _____ Nickname _____
First Middle Initial Last

Address _____

City _____ State _____ Zip _____

☐ Male ☐ Female Age _____ Date of Birth _____ SSN _____

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

Appointment Reminders ☐ Email ☐ Text ☐ Voice If text or voice, which number? _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Spouse Name _____ Phone Number _____

☐ Minor - Parent(s) Name(s) _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Emergency Contact Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance Company _____ Insured Name _____

ID/Claim Number _____ Group Number _____ Insured DOB _____

Secondary Insurance Company _____ Insured Name _____

ID/Claim Number _____ Group Number _____ Insured DOB _____

MEDICAL HISTORY

Referring Physician _____ Primary Care Physician _____

Date of Injury _____ Date of Surgery _____

Date of next physician visit _____

Please check the appropriate response. If not applicable, leave blank.	**YES**	**NO**
Do you smoke?		
Do you exercise regularly?		
Is your current condition work accident related? If yes, date of injury?		
Is your current condition auto accident related? If yes, date of injury?		
Have you had physical, occupational, speech, massage or chiropractic care for any reason this year?		

MEDICAL HISTORY CONTINUED…

Please check YES if you have ever (in your life) had, or do you presently have any of the following

		YES
1	Anemia / Blood Disease	
2	Bone / Joint Problem	
3	Arthritis / Rheumatism	
4	Allergies	
5	Back Trouble	
6	Breathing Problems (any kind)	
7	Broken Bones / Dislocation /	
8	Cancer or Tumor	

		YES
9	Diabetes	
10	Dizziness / Fainting	
11	Epilepsy / Seizure Disorder	
12	Fibromyalgia Syndrome	
13	Headaches	
14	Head / Spinal Injury	
15	Heart Disease / Chest	
16	Hernia / Rupture	

		YES
17	High Blood Pressure or High Cholesterol	
18	Lung Disease	
19	Paralysis	
20	Pregnancy (Current)	
21	Skin Disease or Sores That Won't Heal	
22	Stroke	
23	Swelling of Feet or Joints	
24	Other	

If you have had any prior surgeries please give details below

Surgery / Procedure	Date

MEDICATIONS/ALLERGIES

If you are currently taking any medications please list below:

Medication	
1	
2	
3	
4	

Medication	
5	
6	
7	
8	

Are you allergic to any medications? YES / NO If YES, what? _____

Any other known allergies? YES / NO If YES, what? _____

I certify that I have reviewed and understand the above information supplied by me and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures, patient care, and therapy supplies which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Rebound Sports & Physical Therapy.

Patient or Guardian Signature (if Minor) _____ **Date** _____

Patient Name (print name) _____ **Date** _____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT AGREEMENT, & ATTENDANCE POLICY

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RELEASE OF INFORMATION I, the below named patient, hereby authorize Rebound Sports & Physical Therapy to release to any third party payer (such as an insurance company or governmental agency, example: Anthem BC/BS, UHC, or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with processing a claim for payment for such treatment and/or diagnosis.

INSURANCE ASSIGNMENT I, the below named patient, hereby authorize direct assignment of my rights and benefits for insurance payment to be directed to Rebound Sports & Physical Therapy for any professional services rendered. I understand and agree that the clinic providing services is based on a treatment team approach to care. The treatment team consists of physical therapists, exercise specialists, athletic trainers, interns in training, and massage therapists working under the direction and supervision of the treating physical therapist.

MY RESPONSIBILITY I, the below named patient, understand **it is my responsibility to pay at the time of service** any deductible amount, co-payment, co-insurance, supplies or any other balance not paid for by my insurance. Supplies include, but are not limited to hybresis patches, theraband, kinesiotape, support rolls, and ice packs. All major credit cards and debit cards, checks, and cash are accepted. If you anticipate difficulty in paying, please call our office to discuss a payment plan with one of our billing specialists. If minors will be attending their appointments alone, please make advanced arrangements for payment of services with the billing department. **Please note:** Insurance policies have many different plans covering physical therapy services. We will assist you in any way we can, **but ultimately it is your responsibility to understand your coverage.** If you are unsure of the coverage of your specific plan, we encourage you to contact your insurance company's customer service department. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

PATIENT ATTENDANCE POLICY I, the below named patient, understand that if I am more than 15 minutes late for a scheduled appointment, I may not be able to be seen that day and my appointment will be rescheduled. If you need to cancel an appointment, please provide 24-hour notice by calling during business hours, or leaving a message on voicemail. There is a **$25 charge** for a cancellation without proper notice, or a missed appointment without proper notice (no show). This charge will not be covered by insurance and will be billed directly to you. If you miss 2 or more consecutively scheduled appointments without notice (no show), you may be discharged and a new physical therapy case would be required for you to return to therapy.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT REBOUND SPORTS & PHYSICAL THERAPY. This assignment will remain in effect until revoked by me in writing.

Patient/Guardian Signature _____ **Date** _____

Patient Name (please print) _____

PRIVACY PRACTICES / HIPAA

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PRIVACY PRACTICES I, the below named patient, understand that I am entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also understand that this information can and will be used to convey treatment plan, insurance payments, and administrative activities. I understand and have been given the opportunity to receive a copy of the entire Notice of Privacy Practices prior to signing this consent and understand that I may revoke this authorization in writing, except to the extent that action has already been taken.

HIPAA

I, the below named patient, understand that there may be occasions where I wish to have my protected health information be released to other individuals. This includes, but is not limited to any other health care providers (other than your referring physician), family members, coaches, trainers, etc. I give permission for Rebound to release my protected health information to the persons listed below:

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

I have had the opportunity to review, read and request a copy of Rebound Sports & Physical Therapy's HIPAA Notice of Privacy Practices. In addition to, and in compliance with HIPAA regulations, I give my permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions and appointments, and for claims resolution.

Patient/Guardian Signature _____ **Date** _____

Patient Name (please print) _____

Patient Health Questionnaire

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Patient Name_____ **Date**_____

1. Describe your symptoms _____

_____

a. When did your symptoms start?_____

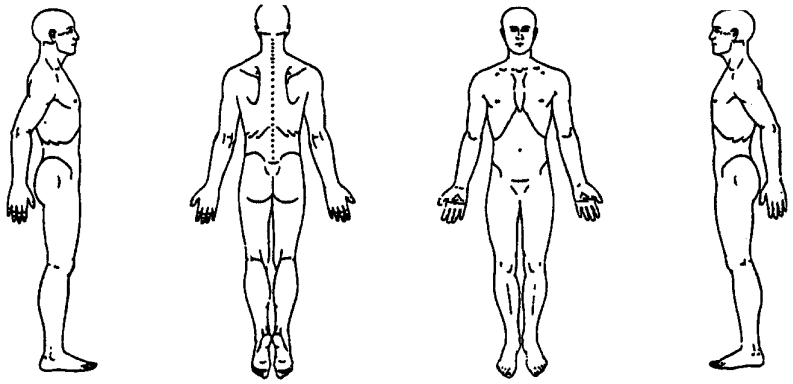
b. How did your symptoms begin?_____

c. What activities produce your symptoms/make them worse_____

_____

2. How often do you experience your symptoms? Indicate where you have pain on diagram below.

- ○ Constantly (100% of the day)
- ○ Frequently (25-75% of the day)
- ○ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ○ Sharp ○ Shooting
- ○ Dull Ache ○ Burning
- ○ Numb ○ Tingling

4. How are your symptoms changing?

- ○ Getting Better
- ○ Not Changing
- ○ Getting Worse

5. During the past 4 weeks:

	None										Worst Imaginable
a. Indicate the worst intensity of your symptoms:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
b. At best, what is the intensity of your symptoms:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

6. In general would you say your overall health right now is…

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

7. Who have you seen for your symptoms? ○ No One ○ Medical Doctor ○ Chiropractor ○ Physical Therapist ○ Other

a. What treatment did you receive? _____

b. What tests have you had for your symptoms and when were they performed? ○ Xrays date:_____ ○ CT Scan date:_____ ○ MRI date:_____ ○ Other date:_____

8. Have you had similar symptoms in the past? ○ Yes ○ No

9. What is your occupation? _____

Patient Signature _____ Date _____