Welcome to Rebound Sports & Physical Therapy!

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 / occupational therapy evaluation:
Your physical therapist/occupational therapist will take a thorough medical history as well as take appropriate measurements and perform physical therapy/occupational 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/occupational 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/occupational 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/occupational 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 or occupational 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/occupational therapy services. These are as follows:

- Medicare requires you to be under the care of a physician. 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/occupational 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 _____ Preferred Name _____
First Middle Initial Last

Home Phone _____ Cell Phone _____

Email _____ Work Phone _____

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

Spouse Name _____ Phone Number _____

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

Emergency Contact _____ Phone Number _____

Emergency Contact Relationship to Patient _____

MEDICAL HISTORY

Referring Physician _____ Primary Care Physician _____

Date of Injury _____ Date of Surgery _____

Date of next physician visit _____

Please check the appropriate response.	**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?		

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	

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MEDICAL HISTORY CONTINUED

Please provide details of any recent/relevant surgeries below:

Surgery / Procedure	Date

CURRENT SYMPTOMS

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. What describes the nature of your symptoms?

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

3. How are your symptoms changing?

   ○ Getting Better ○ Not Changing ○ Getting Worse

4. During the past 4 weeks:

	NONE										WORST
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**

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

6. What is your occupation? _____

MEDICATIONS/ALLERGIES

If you are currently taking any medications please list below:

	Medication
1	
2	
3	
4	

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

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

CONSENT TO TREAT / PRIVACY PRACTICES / HIPAA

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Patient Name (please print) _____

CONSENT TO TREAT

I certify that I have reviewed and understand the 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/Guardian Signature _____ **Date** _____

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_____

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

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PATIENT ATTENDANCE POLICY I, the below named patient, understand that Rebound is fully committed to helping me to reach my rehabilitation and injury prevention goals. I understand that I will receive a printed list of all scheduled appointments and can be provided appointment reminders via email, text, or phone call if desired. I have read the attendance policy outlined below and understand that I play a key role in successfully reaching my goals with regular attendance to my appointments and completing my treatment plan as prescribed by my therapist.

- If you are going to be late for your appointment, please notify the clinic as soon as possible so they can alert your therapist. Please know that if you are going to be more than 10-15 minutes late, your appointment may be rescheduled for another date/time.
- We kindly request 24-hour notice for any appointment you need to cancel to ensure we can help get you rescheduled timely. Please call our front desk at (970)663-6142 to cancel.
- In the event that you cancel 3 or more consecutive appointments without notice, your case will be discharged and a new case would have to be opened for you to return to therapy.
- If you miss an appointment and fail to provide notice (no-show), you will be charged $25. This charge will be directly billed to you and is not covered by any insurance or payor.
- In the event that you fail to provide notice (no-show) for 2 or more consecutive appointments, your case will discharged and a new case will have to be opened for you to return to therapy.

RELEASE OF INFORMATION I, the below named patient, hereby authorize Rebound Sports & Physical Therapy to release to any third party payor (such as an insurance company or governmental agency) 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 authorized medical insurance benefits and request that payment of these benefits be made on my behalf directly to Rebound Sports & Physical Therapy for any professional services rendered. I understand and agree that the professional services include care provided by physical therapists, occupational therapists, exercise specialists, athletic trainers, interns in training, and massage therapists working under the direction and supervision of the treating therapist(s). A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company, or other entity if requested. The original authorization will be kept on file by Rebound Sports & Physical Therapy.

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. All major credit/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/occupational 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.

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) _____