OFFICE USE:
EVAL DATE ____________________
THERAPIST ____________________
ACCOUNT # ____________________
☐ Ins ☐ MC forms ☐ Incident Report
Rx: ☐Rbd ☐gen ☐other PT ☐no RX

REFERRAL INFORMATION

1. Which best describes how you decided to receive your care at Rebound?
   ☐ A good past experience at Rebound ☐ My physician recommended Rebound ☐ Rebound's Location
   ☐ A family member or friend recommended Rebound ☐ Other____

2. Did you request to see the therapist you are scheduled with today? ☐Y ☐N

3. Have you been a Rebound patient before? ☐Y ☐N

4. What physician referred you for care? ____ ☐ I was not referred by a physician

PATIENT INFORMATION

First Name ____________________________________ Last Name ____________________________________ MI_______

Mailing Address ____

City ____ State _________ Zip _________________

Please check which phone numbers we can leave messages on

☐ Home Phone (________) ___________-___________ ☐ Cell Phone (________) ___________-___________

☐ Work Phone (________) ___________-___________ Employer ____

E-Mail Address ____

Date of Birth ________/________/________ Age__________ Social Security # __________-_________-___________

Marital Status: ☐ Married ☐ Single ☐ Other Sex: ☐ Male ☐ Female

Emergency Contact _________________________________ Emergency Contact Phone (_______) __________-__________

Area of Injury____ Date of Injury_________________

RESPONSIBLE PARTY INFORMATION

Who is responsible for payment? ☐ Self ☐ Other Relationship if other: ____________________________________

IF OTHER THAN SELF:

First Name ___________________________________ Last Name _____________________________________ MI _______

Street Address ____

City ____ State _________ Zip _________________

Home Phone (________) __________-_______________ Work Phone (________) __________-_______________

WORKERS COMPENSATION OR AUTO ACCIDENT INFORMATION

MY INJURY WAS: ☐ Work Related ☐ Auto Related Have you notified your insurance company yet? ________

Insurance Company____

If **auto** accident: Name of insured person____

Policy/Claim #__________________________ Date of Injury or accident __________________

In what state did injury occur? _____________ Case Manager/Claims Adjuster _____________________________

Insurance Billing Address____

City_________________________ State______________ Zip Code_______________

Phone: (________) ___________-___________ Fax: (________) ___________-___________

PLEASE SEE REVERSE SIDE

PRIMARY HEALTH INSURANCE INFORMATION
(REQUESTED EVEN IF INJURY IS WORK OR AUTO ACCIDENT RELATED)

Rebound Physical Therapy requires a copy of your insurance card be on file. Please give your card to the receptionist to photocopy. Thank you.

Talk to us about financial options if you are concerned about your insurance coverage!
And please do so at the time of your first visit if possible.

Insurance Company____

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Name________________________________ Subscriber Date of Birth_________________

Subscriber Employer____

Policy_______________________________ Group #________________________

Insurance Billing Address____

City________________________ State______________ Zip Code_______________

Phone: (______) ________-_____________ Fax: (______) ________-_____________

SECONDARY HEALTH INSURANCE INFORMATION

As a courtesy, we are happy to bill your secondary insurance one time.
If you have questions, please contact our Billing Office.

Insurance Company____

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber Name________________________________ Subscriber Date of Birth_________________

Subscriber Employer____

Policy_______________________________ Group #________________________

Insurance Billing Address____

City________________________ State______________ Zip Code_______________

Phone: (______) ________-_____________ Fax: (______) ________-_____________

ACKNOWLEDGMENT

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to Rebound Physical Therapy. I also acknowledge by signing below I accept the terms and agreements made by the attached Patient Financial Responsibility Form, Patient Registration and Consent for Medical Treatment Form.

____
Patient/Responsible Party Signature

MEDICAL HISTORY FORM

PLEASE COMPLETE THE FOLLOWING. IF YOU DO NOT UNDERSTAND A QUESTION, PLEASE ASK YOUR THERAPIST TO ASSIST YOU. THOSE CONSIDERED HIGH RISK MUST HAVE PHYSICIAN CLEARANCE TO PARTICIPATE AT REBOUND PHYSICAL THERAPY. THANK YOU.

NAME____ Today's Date ______________

Date of Birth _________ Height _____ Weight_____ Gender: M F

Do you have a pacemaker? Yes No **Are you pregnant? Yes No**

Occupation ______________________ Presently Working: Full Time___ Part Time___ Not Employed___

Physical Activities at Work: ____

General Health: Excellent___ Good___ Average___ Fair___ Poor___

Date of Last Physical Exam _________________

Exercise Level: None___ 1-2x's/wk___ 3-4x's/wk___ 5+x's/wk___

Type of Exercise:____

Do you experience any symptoms during heavy exercise? Y N

If yes, please explain ____

Stress Level: Low___ Medium___ High___

Hobbies: ____

Are you currently seeing any of the following?

Medical Doctor	Yes	No	Psychiatrist/Psychologist	Yes	No	Chiropractor	Yes	No
Dentist	Yes	No	Physical Therapist	Yes	No	Other_______________	Yes	No

If you have seen any of the above in the last 3 months, please describe for what reason (illness, medical condition, physical exam, etc.).____

In the past 6 months, have you had:

Difficulty with bowel/bladder control	Yes	No	Fever/Chills	Yes	No	Numbness	Yes	No
Numbness in the genital or anal area	Yes	No	Night Pain/Sweats	Yes	No	Weakness	Yes	No
Vision/hearing problems	Yes	No	Dizziness or fainting	Yes	No	Bodily Discomfort	Yes	No
Unexplained weight change	Yes	No	Chest Pain	Yes	No	Shortness of Breath	Yes	No
Leg Swelling	Yes	No	Other ____					

PLEASE SEE REVERSE SIDE

Have you ever been diagnosed as having any of the following?

Cancer Yes No If yes, what kind?____

Heart Problems Yes No Chemical Dependency / Alcoholism Yes No Depression Yes No

High Blood Pressure	Yes No	Hepatitis	Yes No	Stroke	Yes No
Asthma	Yes No	Tuberculosis	Yes No	Anemia	Yes No
Emphysema / Bronchitis	Yes No	Rheumatoid Arthritis	Yes No	Kidney Disease	Yes No
Thyroid Problems	Yes No	Other Arthritic Conditions	Yes No	Allergies	Yes No
Diabetes	Yes No	Epilepsy / Seizures	Yes No	Multiple Sclerosis	Yes No

HIV / Acquired Immune Deficiency Syndrome Yes No Other ______________________________

Do you have any of the following risk factors for Heart Disease?

High Blood Pressure	Yes No	Diabetes	Yes No
High Cholesterol	Yes No	Smoking	Yes No
Heart Disease	Yes No	Family history of heart disease	Yes No

Please list any surgeries or conditions for which you have been hospitalized which may pertain to your current condition.

DATE	SURGERY / HOSPITALIZATION	REASON
__________	____	____________________________________
__________	____	____________________________________
__________	____	____________________________________
__________	____	____________________________________

What medications including prescriptions, herbal remedies and over the counter, in any form (pills, injections, skin patches) are you currently taking?

____

____

Amount of Alcohol Consumption (# of Drinks) per Week _______

Number of Cigarettes / Cigars per Week _______

Does any injury or condition significantly impact your function in these areas?

Work	Yes No	Mobility at Home	Yes No	Food/Meals	Yes No
Personal Care	Yes No	Safety	Yes No	Transportation	Yes No
Finances	Yes No	Emotional stability, including withdrawal or depression			Yes No

Do you have adequate support at home – physical and emotional – to meet the challenges of your condition? Yes No

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For Office Use Only

Patient Name ____ Date of Birth ____________

Form reviewed with patient? Yes ___ No ___ ____

Therapist Signature Date

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for allowing Rebound Physical Therapy to assist you with your rehabilitation. In the interest of good health care practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible.

As a courtesy to you, we will bill your insurance. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting on an insurance claim after 60 days or for managing a disputed claim. Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges, or portions of charges that your insurance does not pay.

Co-Pays are due at the time of service. You will begin receiving monthly statements with any balances after your insurance company has been billed. If you have any questions about your charges or statement, please contact Patient Account Services at 585-2541. The balance of the account is due within thirty (30) days.*

Please contact the clinic if you are not able to keep your scheduled appointment. There will be a $30.00 charge for failure to call and cancel your appointment prior to the scheduled time. Appointments should be cancelled at least 24 hours in advance.

I, the undersigned:

- ❑ have insurance coverage, and authorize direct payment from my insurance carrier to Rebound Physical Therapy, LLC.
  Note: You are responsible for knowing your coverage benefits. Rebound will make every effort to inform you if a supply or service is not covered by your insurance.
- ❑ do not have insurance coverage and understand that I am responsible for payment of all charges.
  Average treatment costs per visit are $200. CareCredit and payment plans through Rebound Physical Therapy are available by request based on your current financial situation.

I have read this credit policy and understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

PRINT PATIENT NAME: ____

PATIENT SIGNATURE: ___________________________________DATE: ____________

PARENT/GUARDIAN must sign if patient is under 18 years of age
SIGNATURE: ____DATE: ____________

*** Please ask the receptionist if you wish to have a copy of this form.**

Rebound Physical Therapy

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Rebound Physical Therapy is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

    a. For treatment – Rebound will communicate with your referring and/or primary care physician to ensure that you receive safe, effective treatment. Your therapist will send your physician a written evaluation and periodic progress notes. He or she may talk with your physician either in person or via telephone or email. Your therapist may request copies of chart notes or radiography reports from your physician.

    b. For payment – Rebound bills your insurance carrier as a courtesy to you or as required by law. All insurance companies require identifying information (including your name, address, birth date and identification number) on claim forms. Additionally, some types of insurance and/or insurance companies require that copies of prescriptions, evaluations and/or daily chart notes accompany the claim form.

    c. For health care operations – Rebound may use your information in calculating the cost of providing care; in reviewing the performance of Rebound staff; and in other business management activities.

2. Rebound Physical Therapy is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.

3. Rebound Physical Therapy intends to engage in the following activities:

    a. Rebound Physical Therapy may contact the individual to provide appointment reminders or information about treatment alternatives or other heath-related benefits and services that may be of interest to the individual or patient.

4. The Individual has the following rights regarding protected health information:

    a. The right to request restrictions on certain uses and disclosures of protected health information. Rebound Physical Therapy is not required to agree to a requested restriction, however.

    b. The right to receive confidential communications of protected health information, as applicable.

    c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

    d. The right to amend protected health information, as provided in the Privacy Regulation.

    e. The right to receive an accounting of disclosures of protected health information.

f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

5. Rebound Physical Therapy is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.

6. Rebound Physical Therapy is required to abide by the terms of the Notice currently in effect.

7. Rebound Physical Therapy reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.

8. Rebound Physical Therapy will provide individuals or patients with a revised Notice by making copies of the revised Notice available in all clinics.

9. Individuals may complain to Rebound Physical Therapy and to the Secretary of the Department of Health and Human Services, without fear of retaliation by Rebound Physical Therapy, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows: Complaint forms are available from office staff at each clinic. The complaint form should be filled out completely and returned to the clinic or directly to the contact listed in 10.a. An investigation will take place and the complainant will be notified in writing of the results.

10. Rebound Physical Therapy's contact person for matters relating to complaints is:

    a. Director of Operations, Privacy officer.

    b. (541) 585-2525.

    c. 805 SW Industrial Way Suite 3 Bend, OR 97702.

11. This Notice is first in effect on April 14, 2003

***Please ask the receptionist if you wish to have a copy of this form.**

Rebound Physical Therapy, LLC

Consent for Release of Protected Health Information

I, _________________________, consent to the release of protected health information that is required to carry out treatment, payment and/or healthcare operations on my behalf.

I have read the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Rebound Physical Therapy is **not** required to agree with my requested restrictions. I also understand that once Rebound Physical Therapy agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that Rebound Physical Therapy must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- Rebound Physical Therapy has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and we will inform you by posting a copy of the revised Notice in the waiting area.
- I hereby acknowledge that I have received a copy of Rebound Physical Therapy's Notice of Privacy Practices.

Individual:	Witness:
______________________	______________________
Printed Name	*Printed Name*
______________________	______________________
Signature	*Signature*
______________________	______________________
Date	*Date*