OFFICE USE:

EVAL DATE ____________________

THERAPIST ____________________

ACCOUNT # ____________________

☐SP Agr ☐Ins card ☐MC Cap ☐Tool
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
   ☐ Media (phonebook, Facebook, internet search, print, etc.) List source(s): ____________________
   ☐ 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

5. Who is your Primary Care Physician? ____________________
   ☐ Same as referring physician
   ☐ I do not have a Primary Care Physician

PATIENT INFORMATION

Legal Name ____________________ (First) ____ (MI) ____________________ (Last) Nickname ______________

Mailing Address ____________________

City ____________________ State _________ Zip ______________

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

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

I am being seen today as a result of an incident that occurred: ☐ At work on the job ☐ In or with a vehicle ☐ Neither
Area of Injury____________________ Date of Injury______________

Primary Phone (________) ___________-___________ Secondary Phone (________) ___________-___________

Your email address will be used only to provide you Rebound news and information. We do not share or sell email addresses.
E-Mail Address ____________________

Employer ____________________ Work Phone (________) ___________-___________

Emergency Contact ____________________ Phone (______) _________-_________ Relationship_________

PARENT/GUARDIAN INFORMATION if patient under 18 years of age

Name ____________________ (First) ____ (MI) ____________________ (Last)

Relationship to the patient: ____________________ Social Security # __________-_________-__________

Street Address ____________________

City ____________________ State _________ Zip ______________

Home Phone (________) ___________-______________ Work Phone (________) ___________-______________

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 ___________ Age_____ 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_________________________		

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 _______________________________					

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

For Office Use Only

Patient Name ______________________________ Date of Birth ____________

Form reviewed with patient? Yes ___ No ___ ______________________________

Therapist Signature Date

rebound
physical therapy

ACUPUNCTURE HEALTH HISTORY

#1 HEALTH CONCERN: ______________________________

WHEN DID THIS FIRST START? _________________________

HOW DOES THIS INTERFERE WITH YOUR DAILY LIFE / ACTIVITIES?

____

____

DOES THIS INTERFERE WITH YOUR SLEEP? YES / NO

IF YES, DESCRIBE: ___________________________________

____

DOES THIS INTERFERE WITH YOUR ENERGY LEVEL? YES / NO

IF YES, DESCRIBE: ___________________________________

____

DOES THIS INTERFERE WITH YOUR EMOTIONAL STATE? YES / NO

IF YES, DESCRIBE: ___________________________________

____

DOES THIS INTERFERE WITH YOUR DIGESTION? YES / NO

IF YES, DESCRIBE: ___________________________________

____

DOES THIS CAUSE HEADACHES? YES / NO # / PER / WK _______

#2 HEALTH CONCERN: ______________________________

WHEN DID THIS FIRST START? _________________________

HOW DOES THIS INTERFERE WITH YOUR DAILY LIFE / ACTIVITIES?

____

____

DOES THIS INTERFERE WITH YOUR SLEEP? YES / NO

IF YES, DESCRIBE: ___________________________________

____

DOES THIS INTERFERE WITH YOUR ENERGY LEVEL? YES / NO

IF YES, DESCRIBE: ___________________________________

____

DOES THIS INTERFERE WITH YOUR EMOTIONAL STATE? YES / NO

IF YES, DESCRIBE: ___________________________________

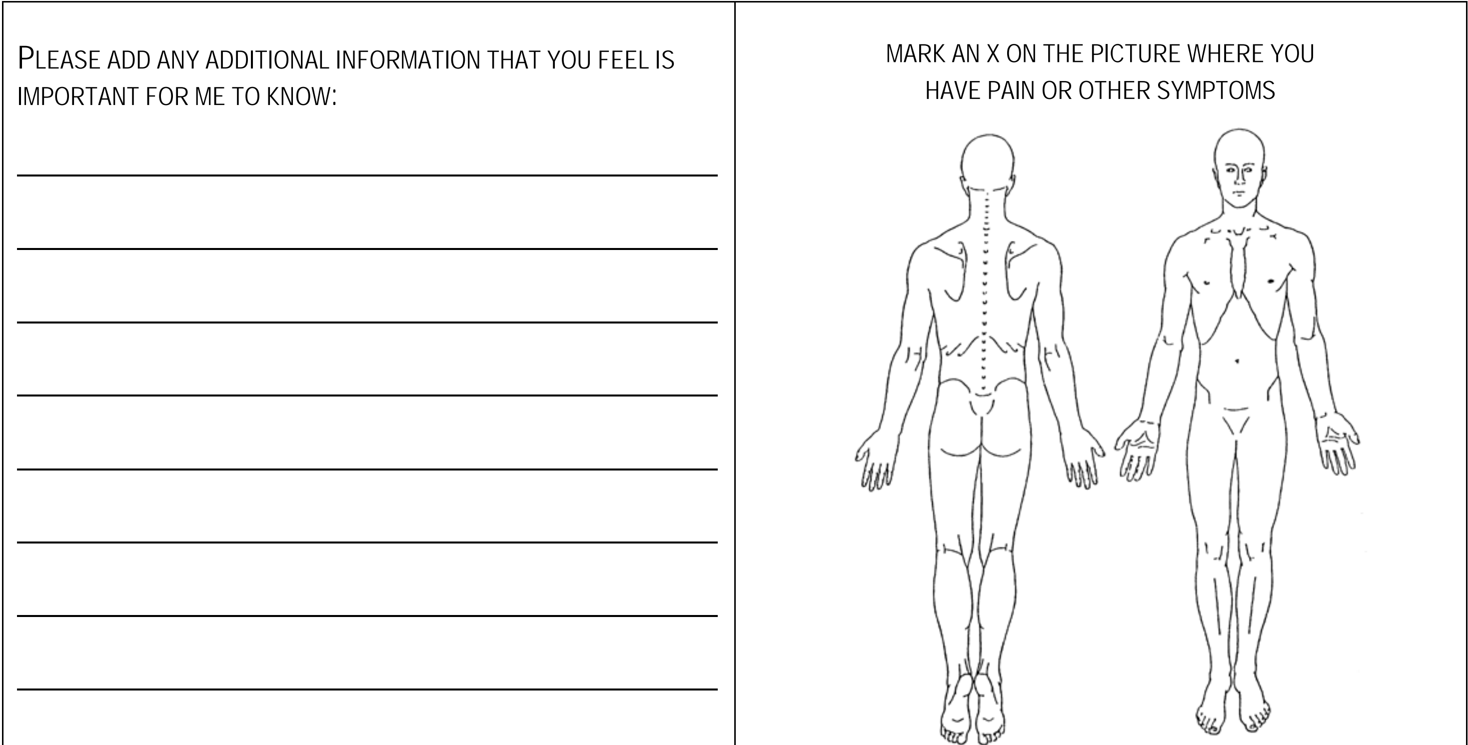
____

DOES THIS INTERFERE WITH YOUR DIGESTION? YES / NO

IF YES, DESCRIBE: ___________________________________

____

DOES THIS CAUSE HEADACHES? YES / NO # / PER / WK _______



PLEASE ADD ANY ADDITIONAL INFORMATION THAT YOU FEEL IS IMPORTANT FOR ME TO KNOW:

____

____

____

____

____

____

____

____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

PATIENT:	FORM REVIEWED WITH PATIENT? YES _______ NO _______	L.AC:	DATE:

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for considering Rebound Physical Therapy for your rehabilitation. We know health care billing and insurance can be complicated and confusing and we want to help make the process more understandable. If you have questions beyond the scope of this agreement please feel free to contact one of our Patient Account Specialists at (541) 585-2541 and they can provide further information and suggestions.

Coverage Information: If you have insurance or other third party coverage please make every effort to give us the correct information and update us with any changes as soon as they occur. Our experienced staff will bill your insurance for you as a courtesy; however we cannot be liable for the benefits which are between you and your insurance company. Further, if we are billing coverage based on inaccurate or incomplete information, payment will be delayed and could ultimately result in a larger portion becoming your personal responsibility. It is our goal to make the financial side of your rehabilitation as stress-free and predictable as possible, but we can only accomplish this with the correct information from you and the receipt of correct information from your insurance company. **Ultimately, you are responsible for knowing your insurance coverage for our services and holding your insurance company accountable to perform.**

Amounts you will owe: It is our policy to collect the appropriate payment due at the time of your visit. This may include your co-pay, deductible, co-insurance, and the amount for any item not covered by your insurance policy.

- **Co-pay:** The part of your medical bill you must pay each time you visit your therapist. This is a pre-set fee determined by your health insurance policy.
- **Deductible:** The amount you must pay before your insurance company begins to pay – for instance, $1,000 per individual and $2,500 per family. This amount typically resets at the beginning of the year.
- **Co-insurance:** This is the part of your bill, in addition to co-pay, that you must pay personally. This amount is usually expressed as a percent of the allowable charges – for example, 20 percent.
- **Non-covered items:** From time to time your therapist may suggest treatment and or products that could be beneficial to your recovery process but which are not covered by your insurance policy. If you choose to take advantage of these non-covered services you will be responsible to pay for them.

These amounts become your responsibility at each visit. We strongly encourage you to come prepared to pay these amounts at each visit to avoid the unpleasant event of a large accumulated bill after completion of treatment. If you believe you may have difficulty paying your portion for services at each visit, please contact one of our Patient Account Specialists at the number above to discuss your options.

Please contact the clinic at least 24 hours in advance if you are not able to keep your scheduled appointment. Failure to do so could result in a $30.00 charge to your account.

I, the undersigned:

☐ Have insurance coverage and I authorize direct payment from my insurance carrier to Rebound Physical Therapy.

☐ Do not have insurance coverage and understand that I am responsible for payment of all charges.
Average treatment costs per visit are $200. We can offer you a discount if you pay at the time of service.

I have read this agreement and understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account within six months of my last visit. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES.

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.**

Informed Consent to Receive Acupuncture Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and Oriental medicine by a licensed acupuncturist. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin and/or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment and very rarely lung puncture (pneumothorax). I understand that I may refuse this therapy at any time.

Direct Moxibustion/Infrared Mineral Lamp: I understand that I may receive direct moxibustion/infrared mineral lamp as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: a risk of burning or scarring, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Electro-Acupuncture: I understand that I may receive electro-acupuncture as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Cupping: I understand that I may receive cupping as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: deep redness, discoloration or bruising, on rare occasions blistering may occur, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Acupressure/Tui-Na Massage: I understand that I may receive acupressure/tui-na massage as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturist <u>before</u> proceeding with acupuncture.

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Printed Name: ____ **Date of Birth:** _______________

Signature: ____ **Date:** ______________________

PARENT/GUARDIAN must sign if patient is under 18 years of age

Signature: ____ **Date:** ______________________

L.Ac: ______________________ Date: ______________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures
There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Your confidential medical information is defined under federal law as "protected health information" ("PHI"). When we retain your confidential medical information on its computer system, it is called "electronic protected health information" ("ePHI"). This Notice applies to all PHI and ePHI related to your care that we have created or received. It also applies to any personal or general information we receive from patients, including information contained on driver's licenses. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

USE AND DISCLOSURE WITHOUT PATIENT ACKNOWLEDGEMENT OF THIS NOTICE

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

USE AND DISCLOSURE WITHOUT ACKNOWLEDGEMENT OR AUTHORIZATION

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

AUTHORIZATION FOR USE OR DISCLOSURE

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records without your specific written consent and authorization. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization. Your medical information will not be disclosed for marketing purposes or sold to any third party without your authorization. We will not disclose medical information about you to your family members or friends without your verbal or written authorization or if we give you an opportunity to object to such disclosure and you do not raise an objection. We may also disclose medical information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your medical information to your spouse when you bring your spouse with you into the room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only medical information relevant to the person’s involvement in your care. Other uses and disclosures of your medical record 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 with permission to use or disclose information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to “take back” any disclosures that we have already made with your permission and that we are required to keep any records of the care that we provided to you.

ADDITIONAL USES AND DISCLOSURES

Advice of Appointment and Services: Rebound Physical Therapy may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may interest you. The following appointment reminders may be used by Rebound Physical Therapy: a) postcard mailed to you at your address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

Individual Rights
You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2. You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services out of your own pocket, in full. This does not apply to services that are covered by insurance. You are required to pay cash, in full, for the services before the restriction applies.

3. With respect to ePHI, we agree to give you your ePHI in the form and format requested by you, if it is readily producible in that form or format. If it is not readily producible in the form or format requested, we will give you a readable hard copy form. Any directive given to us by you to transmit ePHI must be done in writing by you, signed and clearly identify the designated person and location to send the ePHI. We will provide you access to your PHI or ePHI within thirty (30) days from the date of request.

4. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

5. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

6. We may deny any request for amendment of your PHI or ePHI if the information was not created by us (unless the originator of the information is no longer available to act on your request); is not part of the designated record set maintained by us; is not part of the information to which you have a right of access; or is already accurate and complete, as determined by us. If we deny your request for an amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

7. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to “Privacy Officer” at our address. We will respond to your request in a timely fashion.

8. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.

9. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish. A copy of this notice is also available to you on our website.

10. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.

11. You have the right to receive notification from us if any breach of your unsecured protected health information occurs.

Our Duties

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.

2. We are required to abide by the terms of this Notice currently in effect.

3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website: http://www.hhs.gov/ocr/hipaa.

This Notice of Privacy Practices shall not be construed as a contract or legally binding agreement. Any non-compliance with any provision of this Notice shall not be construed as a breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law. By signing the Acknowledgment of Receipt of this Notice, you agree that the sole legal recourse for our non-compliance with this Notice is to file a written complaint to the Secretary of the U.S. Department of Health and Human Services, and that no complaint or cause of action may be filed in any federal or state court for breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law, or under any tort theory.

Contact Person

All questions concerning this Notice, or requests made pursuant to it, should be addressed to:
Jennifer Richardson, Privacy Officer, at the following address:
805 SW Industrial Way
Bend, OR 97702
or E-mail: jrichardson@reboundoregon.com

Effective Date

This Notice is effective **September 23, 2013 and revised September 23, 2013** and applies to all protected health information contained in your medical records maintained by us.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Rebound Physical Therapy** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I have read the Notice of Privacy Practices and acknowledge and understand the following:

- This information serves as a basis for my continuing care.
- This information is used as a means of communication among Rebound Physical Therapy's personnel, and with medical personnel outside of this practice.
- This information serves as a source of information for applying my diagnoses and surgical information to my bill.
- This information is a way for third party insurance companies to assure that a service we billed for was actually performed.
- This information can be used as a tool to assess the quality of care provided to patients.
- I have been provided an opportunity to review the Notice of Privacy Practices for Rebound Physical Therapy that provides a more complete review of information uses and disclosures.
- I have the right to review this Notice of Privacy Practices before signing this consent.
- Rebound Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.
- I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Rebound Physical Therapy is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices of Rebound Physical Therapy and agree to the liability limitations explained therein.

________________________________	____________	____________________
Signature of patient or legal representative	Date	Relationship to Patient

____

Printed name of patient

Effective date September 23, 2013
Revised date September 23, 2013