Rebound
Sports and Orthopedic Physical Therapy, LLC

First:_____ **Middle Initial**_____ **Last:** _____
Patient Mailing Address:_____
City:_____ **State:**_____ **Zip:**_____ **Date of Birth**_____/_____/_____
Social Security #:_____-_____-_____ **Patient Hm Phone:** _____ **Cell #:**_____
Email : _____ **Gender: Male** ___ **Female**___
Marital Status: Single___**Married**____**Other**____ **Spouse's Name (if applicable):**_____
Emergency Contact:_____ **Relationship:**_____ **Phone:**_____
Patient's Current Employer:_____ **Phone:**_____
Referring Physician:_____ **Office Name:**_____
How did you hear about us? (check one) Physician____ **Friend**____**Other**_____

PRIMARY INSURANCE

Primary Insurance Carrier:_____
Guarantor/ Policy Holder Name:_____
Relationship:_____ **Policy Holder's Date of Birth :**____/_____/_____

SECONDARY INSURANCE (if applicable)

Secondary Insurance Carrier:_____
Guarantor/ Policy Holder Name:_____
Relationship:_____ **Policy Holder's Date of Birth :**____/_____/_____

CONSENT FOR CARE

I understand that I am responsible for all fees regardless of insurance coverage. I am responsible for furnishing all insurance information correctly prior to treatment unless other arrangements have been made in advance. I authorize Rebound Sports and Orthopedic Physical Therapy, LLC to examine me, administer treatment as necessary and perform procedures that are considered therapeutically or diagnostically necessary.

BILLING POLICY

I understand that it is my responsibility to provide Rebound Sports & Orthopedic Physical Therapy with current, accurate billing information at the time of check-in and to notify Rebound of any changes in this information.

I understand that it is my responsibility to know my co-pay and/or co-insurance benefits prior to services being rendered. I understand that my insurance plan benefit booklet and/or a representative from my insurance carrier can assist me in obtaining this information if Rebound is unable to verify benefits prior to treatment.

I understand that if I present an insufficient funds (NSF) check for payment on my account, I will be charged a $25 NSF fee.

I understand that I will be billed for any amount due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment after the second statement, that my account will be flagged for Collection Review and sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

My signature below confirms that I have read and agree with the consent for care and the billing policy and understand my financial obligation as it pertains to Rebound Sports & Orthopedic Physical Therapy, LLC.

Signature_____ **Date**_____

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT
AT REBOUND SPORTS & ORTHOPEDIC PHYSICAL THERAPY

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Board of the State of Alaska.

I hereby consent for my therapist to treat me with massage therapy including such assessments, examinations, and techniques which may be recommended by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness, disease, or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I visit my primary care physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of this treatment.

I acknowledge that with any treatment there can be risks, that those risks have been explained to me, and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed the medical history form as provided to me by my therapist and I have disclosed all medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above statements and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist to address my physical condition for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be discontinued.

Client Name (print) _____

Client Signature_____Date _____

Signature of Parent/Guardian_____Date_____

Witness _____Date_____

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MASSAGE THERAPY ATTENDANCE POLICY

At Rebound Sports & Orthopedic Physical Therapy, we recognize that the need to occasionally reschedule appointments is a part of life. However, missed appointments do not allow us the opportunity to provide quality care to you or to others. As such, we ask that you read and abide by the policies below.

Collection of Fees:
We require that our patients provide a valid credit card to be entered into our secure and encrypted credit card system prior to booking a massage. Should you no-show a massage appointment, Rebound will charge your card on file the respective fee amount as noted below.

No-Shows:
No-shows are defined as a missed appointment without any communication from you, the patient, prior to your appointment time. If you no-show an appointment, there will be a $50 no-show fee charged to your credit card on file.

Responsibility of the Patient:
Insurance cannot be charged for services that are not rendered. Should you no-show a massage appointment, you will personally be responsible for the respective fee associated with that visit. These fees cannot be billed to or covered by insurance.

I acknowledge receiving and understanding Rebound's attendance policy for massage appointments. I agree that I will be responsible for paying a fee of $50 if I no-show my massage appointment.

Signed _____ Date _____

To change or cancel an existing massage appointment, please contact your provider via call or text at 907-375-5555 (West) or 907-341-5555 (South). Thank you for your consideration and understanding.

Medical History Form

Medications affect tissues in various ways. It is important for your massage therapist to be aware of any medications you are taking in order to provide the most beneficial treatment(s) for your individual needs. Please indicate if you are taking any version of the following medications:

	YES:	NO:
▪ Anti-diabetic drugs, insulin, or oral medications to control diabetes	☐	☐
• Anti-coagulants (blood thinners) like Coumadin or Heparin	☐	☐
• Anti-anxiety medications such as Xanax, Valium, or Ativan	☐	☐
• Anti-arrhythmics or beta blockers such as Betaloc, Blocadren, Lopressor, or Tenormin	☐	☐
• Antibiotics/Antibacterials	☐	☐
• Corticosteroids or gluco/mineralcorticoids such as Codeine, Demerol, Dilaudid, or Duragesic	☐	☐
• Narcotic analgesics (prescription pain medications) such as Contin, Roxanol, Sublimaze, Oxycontin, Byprenex, Hydrocodone, Loratab, Vicodin, Demerol, Fentora, or more than 400mg of Advil or Ibuprofen	☐	☐
• Potassium-sparing diuretics such as Aldactone, Dyrenium, Inspra, or Kaluri	☐	☐
• Skeletal Muscle Relaxants	☐	☐

If you are taking any other medications, please list the name and use:_____

_____

Are you currently pregnant? ☐ Yes ☐ No **If yes, how far along**? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ Yes ☐ No **If yes, please explain**: _____

What makes your pain better? _____

What makes your pain worse? _____

Have you had any orthopedic injuries? ☐ Yes ☐ No

If yes, please list and indicate P for past or C for Current:

_____

_____

Please indicate any of the following that apply to you:

☐ Cancer	☐ High/Low Blood Pressure	☐ Kidney Dysfunction
☐ Headaches/Migraines	☐ Neuropathy	☐ Blood Clots
☐ Arthritis	☐ Fibromyalgia	☐ Numbness
☐ Diabetes	☐ Stroke	☐ Sprains or Strains
☐ Joint Replacement(s)	☐ Heart Attack	

Please explain any conditions marked above:

_____

_____

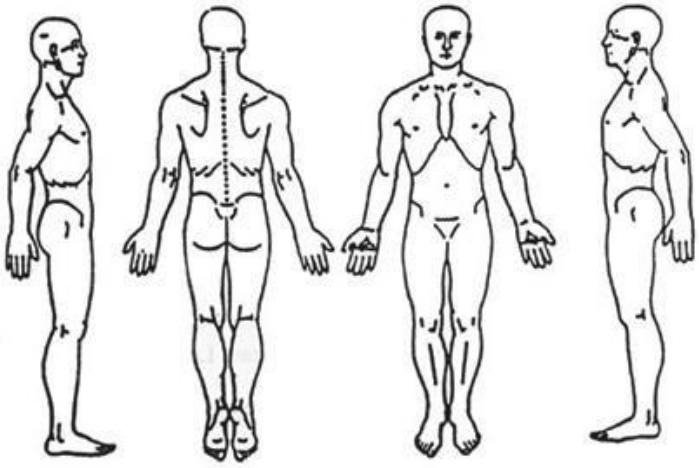
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. Additionally, I understand that if my insurance plan does not coverage massage therapy at Rebound Sports and Orthopedic Physical Therapy, I will be responsible for paying the out-of-pocket rate of $90/hour.

Client Name _____

Client Signature _____ Date _____

For Your Massage

Please mark any areas of discomfort with an "X":



Do any of the follow apply to you today? Please indicate:

☐ Cold/Flu
☐ Open cuts/wounds or bruises
☐ Infections
☐ Skin Rash
☐ Recent surgery
☐ Pregnancy
☐ Headache
☐ Dizziness

List any medications you have taken in the last 24 hours:_____
_____
_____

Have you had a professional massage before? ☐ Yes ☐ No

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic ☐ Sports

What type of pressure do you prefer? ☐ Light ☐ Medium ☐ Deep ☐ Depends on Tissues

Are there any areas (such as your feet, face, abdomen, etc.) you do not want massaged? ☐ Yes ☐ No
If yes, please specify:_____

Do you have any allergies or sensitivities? ☐ Yes ☐ No
If yes, please specify: _____

Client Name: _____

Client Signature: _____ **Date:** _____