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**_____

WORK COMP INFORMATION

Insurance Company:_____ **Claim #:**_____
Adjuster's Name:_____ **Phone:**_____
Date of Injury:_____/_____/_____
Name of your employer at time of injury:_____

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**_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Rebound Sports and Orthopedic Physical Therapy, LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Rebound Sports and Orthopedic Physical Therapy, LLC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Rebound Sports and Orthopedic Physical Therapy, LLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to **Rebound Physical Therapy, LLC; PO Box 110171; Anchorage, AK 99511.** The Notice of Privacy Practices may also be reviewed at www.reboundptak.com.

With this consent, **Rebound Sports and Orthopedic Physical Therapy, LLC** may call my home or other alternative location and leave a message on voicemail or in person on reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Rebound Sports and Orthopedic Physical Therapy, LLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Rebound Sports and Orthopedic Physical Therapy, LLC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Rebound Sports and Orthopedic Physical Therapy, LLC** restrict how it uses or disclosed my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Rebound Sports and Orthopedic Physical Therapy, LLC** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Rebound Sports and Orthopedic Physical Therapy, LLC** may decline to provide treatment to me.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____ _____
Signature of Witness Date

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Medical History Form

Name (please print): _____ Age:_____ Height: _____ Weight: _____

Injury or reason for receiving therapy: _____

Date of injury or onset:_____ Date of Surgery (if applicable):_____

Occupation:_____

Are you currently working? YES_____ NO_____ If no, is it because of your injury? YES_____ NO_____

What physical activities does your job require? _____

Are you currently on restricted duty? YES_____ NO_____

Do you smoke/use tobacco? _____ Allergies? _____ Unexplained weight loss/gain? _____lbs

Have you fallen within the last year? YES_____ NO_____ If so, how many times? _____ Were you injured? _____

List all medications you are currently taking: _____

_____ None: ☐

Have you had any of the following conditions? Are you taking medications for them? If yes, check the box that applies.

	Yes	Meds		Yes	Meds		Yes	Meds
Heart Trouble	☐	☐	Epilepsy	☐	☐	Diabetes	☐	☐
High Blood Pressure	☐	☐	Stroke/CVA	☐	☐	Fracture	☐	☐
Bleeding Disorder	☐	☐	Asthma	☐	☐	Cancer	☐	☐
Headaches	☐	☐	Emphysema	☐	☐	Pacemaker	☐	☐
Bladder/Bowel	☐	☐	Back/Neck Pain	☐	☐	Dizziness	☐	☐
Fainting Spells	☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐
Osteoporosis/penia	☐	☐	Depression	☐	☐	Pregnancy	☐	☐
Lymphedema/ Swelling	☐	☐	Fibromyalgia	☐	☐	Other	☐	☐

What makes your pain worse? (circle all that apply)

sitting standing walking driving bending

sleeping reaching stairs Other: _____

What makes your pain better? (circle all that apply)

bending forward standing sleeping walking sitting

bending backward laying flat Other: _____

What is your pain **now**? 0 1 2 3 4 5 6 7 8 9 10

What is your pain at **worst**? 0 1 2 3 4 5 6 7 8 9 10

What is your pain at **best**? 0 1 2 3 4 5 6 7 8 9 10

Signature: _____

Date: _____

Please mark the location and type of pain or the area of injury