Patient Information

Today's Date:_____

Patient Name:_____

Last First Initial

Street Address:_____

City:_____ State:_____ Zip:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ **Cell phone**:_____

***Text reminder**: ☐ **Cell Provider**:_____

*Note by checking the text reminder box you authorize certain PHI to be disclosed (ie: name, email, appointment information)

Email address:_____

Birthdate:_____ **Gender**: M F

Soc. Sec. #:_____-_____-_____ (optional)

Please complete the following as applicable:

Employer:_____ **Phone**:_____

Business Address:_____

City:_____ State:_____ Zip:_____

Occupation:_____

Marital Status (circle one): S M W D

Spouse Name:_____

Employer:_____ Phone:_____

Birthdate:_____

Please complete if patient is a minor or dependent:

Mother's Name: _____

Employer:_____ Phone:_____

Birthdate:_____ Soc. Sec. #:_____-_____-_____

Father's Name: _____

Employer:_____ Phone:_____

Birthdate:_____ Soc. Sec. #:_____-_____-_____

Closest Relative or Friend (not living with you):

Name:_____ Phone:_____

Address:_____ City/ST:_____

Do you have a follow-up appointment with the doctor who referred you to physical therapy (*Required for Medicare)*?

☐ YES Date of appointment:_____

Referring Dr. _____

☐ NO, I am to call the doctor to schedule a follow up

☐ NO, doctor did not request to see me again

Insurance Information:

Is this a Motor Vehicle Accident claim? ☐ YES ☐ NO

If yes, Date of injury:_____ State: _____

Is this a Workman's Comp. claim? ☐ YES ☐ NO

If yes: Date of injury_____

Claim # (if work. comp. or MVA):_____

Primary Ins:_____

ID#:_____ Group #:_____

Address:_____

_____Phone:_____

Secondary Ins:_____ ID#:_____

Address:_____

_____ Phone:_____

How did you hear about Rebound Physical Therapy?

____ Physician

____Advertising

____Friend/Family Whom?_____

Rebound Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly. ***However, the patient is responsible to understand the specifics of their individual insurance coverage. The insurance contract is between the covered individual and the insurance company***. The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions.

☐ I hereby consent to such physical therapy procedures as may be rendered by Rebound Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Rebound Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. A $20.00 fee will be charged for returned checks. Rebound Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Rebound Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

☐ I acknowledge that I have been informed and notified of the whereabouts of Rebound Physical Therapy's notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information).

_____

Patient/Guardian's Signature **Date**