PATIENT REFERRAL FORM

Appt Date: **Time:** **w/**

Patient Name:_____ DOB:_____ Gender: M / F
Phone:_____ Email:_____ Reminder Text: Yes No
Address:_____ City_____ Zip_____
Emergency Contact:_____ Phone:_____ Relationship_____

Referring Physician:_____ NPI: _____ Phone:_____
DX:_____ Fax:_____

Additional Information: (Must complete if Accident Related)
Case Manager:_____ Claim# _____
Phone #_____ Fax #_____ Accident Date:_____ Auto WC Other
Employer Name:_____ Employer Address:_____ City_____ ZIP_____
Work Number:_____

INSURANCE VERIFICATION

Primary Ins: _____ **Phone#** _____
ID# _____ **Group#** _____ **HRA/HSA**
Ins. Policy Holder: _____ **DOB:** _____ **Relationship:** _____
Ins. Policy Holder SSN: _____

Verified by: _____ Date: _____
Ins. Rep._____ Ref #:_____
Effective Date: _____ Calendar Year / Contract Year
Co-Insurance: %:_____ Co-payment: $_____
Ind. Ded $_____ Met $_____ Fam Ded $_____ Met $_____
OOP Max $_____ Met $_____ Fam OOP Max $_____ Met $_____
Referral Required: Yes No Authorization Required: Yes No Through: _____
Max/Auth # visits allowed _____/_____ Used to date_____ Auth Exp Dt: _____
Home Health: Yes No Hospice: Yes No HMO: Yes No
Claims Address (if not on file):

Secondary Ins: _____ **Phone #** _____
ID# _____ **Group #** _____ **HRA/HSA**
Ins. Policy Holder: _____ **DOB:** _____

Verified by:_____ Date:_____
Ins. Rep._____ Ref #:_____
Effective Date:_____ Calendar Year / Contract Year
Co-Insurance: %:_____ Co-payment: $_____
Ind. Ded $_____ Met $_____ Fam Ded $_____ Met $_____
OOP Max $_____ Met $_____ Fam OOP Max $_____ Met $_____
Referral Required: Yes No Authorization Required: Yes No Through:_____
Max/Auth # visits allowed _____/_____ Used to date_____ Auth Exp Dt: _____
Home Health: Yes No Hospice: Yes No HMO: Yes No
Claims Address (if not on file):

CONSENT FOR TREATMENT
RELEASE OF INFORMATION
HIPAA PRIVACY NOTICE
FINANCIAL AGREEMENT

Patient Name: _____ **Date:** _____

CONSENT: I do hereby agree and give my consent for **Rebound Physical Therapy** to furnish Therapy Treatment. _____(Please initial)

Rebound PT has my permission to allow students to observe my treatment and care. Yes _____ NO _____**(check yes or no)**

RELEASE OF INFORMATION: I agree that **Rebound Physical Therapy** may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including , but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS YOUR PHI and/or BILLING INFORMATION.

Name: _____ Relationship _____ PHI _____ Billing _____

Name: _____ Relationship _____ PHI _____ Billing _____

HIPAA PRIVACY NOTICE: I acknowledge that I have received the HIPAA Privacy Notice and have had the opportunity to review its content. _____ **(Please initial)**

FINANCIAL POLICY STATEMENT: As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payments at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to Rebound Physical Therapy.
The above does not apply for those patients that are considered Workers' Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

*******ARE YOU BEING TREATED AS A RESULT OF AN AUTO ACCIDENT: YES _____ NO____**
(If yes, have you supplied _____ with your claim information?)

*******ARE YOU BEING TREATED AS A RESULT OF A Work Comp ACCIDENT: YES _____ NO ____**
(If yes, have you supplied _____ with your claim information?)

*******ARE YOU BEING TREATED AS A RESULT OF AN ACCIDENT OF ANY KIND: YES _____ NO _____**

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party **Date**

_____ _____
Rebound Physical Therapy/Witness **Date**

Rebound
Physical Therapy

Dear Patient,

Please remember, we require **24 hours notice** when canceling an appointment. We understand that things come up at the last minute but please try to give us as much notice as possible when canceling or rescheduling your appointment. Breaking an appointment without proper notice hinders our ability to care for you as well as others, because we lose a time slot that could have been used to help another patient.

As a company policy please be aware that there will be a **$25** charge for any **NO SHOW** appointment. This is *not covered by your insurance* company and will be expected to be paid in full at your next visit.

Thank you for your understanding and compliance with this policy.

Print Patient Name _____

Patient Signature _____ Date: _____

Rebound Physical Therapy
980 Woodstock Pkwy.
Suite 200
Woodstock, GA 30188

678.445.9799 Office

www.ReboundPTClinic.com

Patient Health Information Name: _____

Please put a check in the box next to any medical conditions you may have, or have had in the past.

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Lupus/SLE
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Osteoporosis
- ☐ Headaches/Migraines
- ☐ Leg Cramps
- ☐ Jaw pain/TMJ
- ☐ Bulging Disks
- ☐ Other: _____

Circulation/Respiration
- ☐ Heart Condition
- ☐ Heart Attack
- ☐ Heart Arrhythmias
- ☐ Pace Maker
- ☐ High Cholesterol
- ☐ Blood Clots/Phlebitis
- ☐ Anemia
- ☐ Other: _____

Digestion
- ☐ Diabetes
- ☐ Kidney Problem
- ☐ Irritable bowel
- ☐ Bladder problem
- ☐ Liver problem
- ☐ Hernia
- ☐ Other: _____

Nervous System
- ☐ Stroke/TIA
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Epilepsy/Seizures
- ☐ Concussion/Brain injury
- ☐ Numbness or tingling
- ☐ Vertigo
- ☐ Other: _____

Infectious Diseases
- ☐ TB
- ☐ Hepatitis
- ☐ Polio
- ☐ Other: _____

Skin
- ☐ Skin allergies/rashes
- ☐ Eczema/psoriasis
- ☐ Infectious skin diseases
- ☐ Shingles
- ☐ Latex Allergy
- ☐ Other _____

Please list any prior accidents, broken bones, or surgeries with approximate dates: _____

_____

1. Have you fallen in the last year? _____
2. Have you had surgery for this injury? Yes___ No___ Surgery Date(s): _____
3. When did pain begin? (Date of Injury) _____
4. Have you had any Medical or Rehabilitative services for this injury/episode? Yes ___ No ___
5. Are you currently taking any prescription or non-prescription medications? If so please list them: _____

_____

6. Do you Smoke? Yes ___ No ___ 6. Are you pregnant? Yes ___ No ___
7. Based upon your awareness, what are your expectations/goals while in Therapy? _____

_____

_____

8. Height _____ Weight _____

Patient/Guardian Signature: _____ Date: _____