REHAB PLUS
PHYSICAL THERAPY SPORTS PERFORMANCE

Patient Registration Information

Please Print

Full Legal Name: First Middle Last _____ - - _____ Social Security Number

Address: Street Apartment # _____ ( ) _____ Home Phone Number

City State Zip Code _____ ( ) _____ Mobile Phone Number

Male Female (circle one) ___/___/___ Date Of Birth Single Married (circle one) _____ Spouse or Parent (if minor) _____ ( ) _____ Spouse/Parent Phone Number

Occupation _____ School Name if student _____ Employer _____ ( ) _____ Work Phone Number

Email Address _____ How were you referred to Rehab Plus _____

Is your injury the result of an accident? **No** **Yes** (circle one) If yes, was it **work related** **motor vehicle accident** **Other**:_____ (circle one)

Appointment Reminders will be sent via Text Messaging. Please state your service provider:_____ (Verizon, Sprint, T-Mobile, US Cellular, etc.)

Insurance Information

_____ ( ) _____ Insurance Company Ins Co Phone Number _____ Policy ID Number _____ Group Number

_____ ___/___/___ _____ Policy Holder's Name Date of Birth Relationship to Patient

Worker's Compensation Information

_____ Worker's Compensation Carrier Address: Street City, State Zip

_____ _____ ( ) _____ Claim Number Case Manager Case Manager Phone #

___/___/___ _____ _____ Date of Injury Employer at time of injury Employer Phone Number

RELEASE OF INFORMATION

I give permission to Jeff Kitchen, Inc. (Rehab Plus) to release information to my referring physician(s), surgeon(s), insurance company, attorney, assignees, and/or beneficiaries.

ASSIGNMENT OF BENEFITS

I authorize payment directly to Jeff Kitchen, Inc for services I receive. Any payments made to me by third party payer services provided by Jeff Kitchen, Inc will be immediately (within 5 days) transferred to Jeff Kitchen, Inc.

PAYMENT GUARANTEE

In consideration of the services rendered and to be rendered to the above named patient by Jeff Kitchen, Inc expressly guarantee payment of this account and agree to pay any charges left unpaid in whole or in part by the insurance company. Should this account proceed to collection agency or court, I will be responsible for both the cost of billed services, as well as cost of collections and any and all attorney and court fees associated with the collection process. The patient is ultimately responsible for account totals and balances. A $10 processing fee is applied for each subsequently mailed statement.

_____ Signature of Responsible Party or Legal Guardian If Minor Date

By signing above, you, as the patient or legal guardian, agree to the terms and conditions listed under "Release of Information", Assignment of Benefits", and "Payment Guarantee". **Any unilateral alteration, strikeover or modification to the preprinted text or line entries of this document and legal agreement shall be of no effect whatsoever, and at Jeff Kitchen Inc.'s sole discretion, may render this document invalid.**

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Patient Medical History Form

Name_____ Age_____

Occupation_____ _____

Type of work, examples: lifting, prolonged sitting, standing, etc.

Injury/Reason you are here?_____

If you had surgery for this injury, what was the date of surgery? _____

Past Medical History:

Do you have any previous history of:

Diabetes	☐ Yes	☐ No	Pulmonary Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Blood Pressure Problems	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Knee Surgery	☐ Yes	☐ No	☐ None Significant		
Heart Disease	☐ Yes	☐ No	Back Surgery	☐ Yes	☐ No	☐ Other_____		

Which of the following aggravates your condition?

☐ Walking	☐ Bending	☐ Change of Direction	☐ Lying Prone	☐ Overhead Activities
☐ Standing	☐ Lifting	☐ Up Stairs	☐ Lying Supine	☐ Impinging Positions
☐ Sitting	☐ Running	☐ Down Stairs	☐ Sidelying	☐ Prolonged Immobility

What eases your symptoms?

☐ Resting	☐ Medication	☐ Supine with feet elevated	☐ Other_____
☐ Avoidance	☐ Walking	☐ Frequent change of position	
☐ Modalities	☐ Standing	☐ None	

Have you been admitted to the hospital or had any surgical procedures during the last 5 years: ☐ Yes ☐ No

What was this condition?_____

Is this condition the reason you were referred to physical therapy? ☐ Yes ☐ No

Have you received any physical therapy treatments during the past 5 years? ☐ Yes ☐ No

If yes, for what condition and was the treatment effective? _____

Have you had any other previous medical problems or surgeries? ☐ Yes ☐ No

If yes, please specify: _____

Did you receive any special tests while in the hospital or as an out-patient? Example: CAT Scan, EMG, EKG, MRI

☐ Yes ☐ No If yes, please specify: _____

Have you had any previous orthopedic problems? ☐ Yes ☐ No

If yes, please specify: _____

Medications? What type and what for? _____

Exercise/Activity level: _____ 0 days/week _____ 1-2 days/week _____ 3-5 days/week _____ 6-7 days/week

What types of activities? _____

Name of your orthopedic and/or primary doctor? _____

_____ _____

Patient Signature Date

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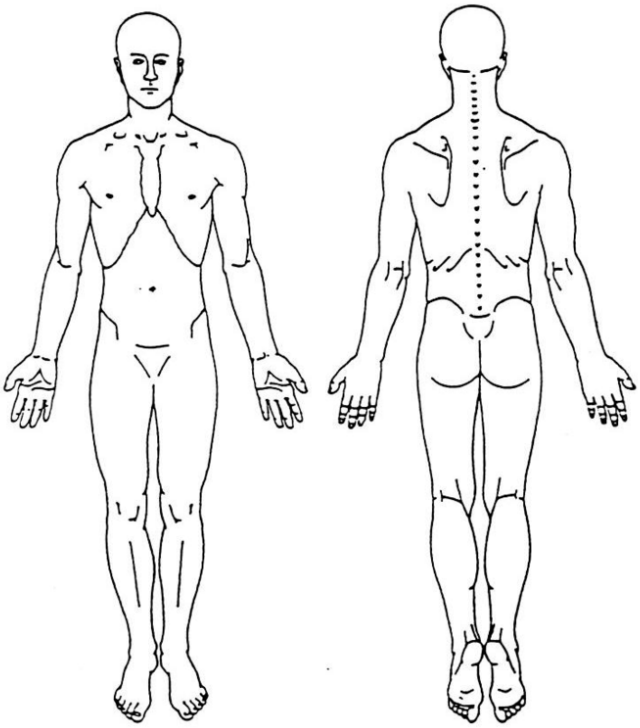
BODY DIAGRAM

Date:_____ **Patient Name:**_____

Please indicate with "xxx" on the chart below where your pain typically presents:



On a scale of 1 to 10, (1 being minimal pain and 10 being excruciating), please rate your overall pain:

At worst: _____
At best: _____
On average: _____

Please indicate the date of your current injury: _____
If uncertain, approximate please

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Financial Policy and Patient Responsibility
Acknowledgement of Receipt of Notice of Privacy Practices

Rehab Plus Sport Therapy is committed to providing our patients with the highest quality care.
We thank you for taking the time to read and understand our policy.

It is the Patients Responsibility:

- **To know their insurance policy**. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- **To report any changes to their insurance policy**, including, but not limited to cancellations, terminations, policy number changes, group number changes, etc and to supply a copy of the new insurance information prior to the next therapy session. Any non-covered/denied services will be the responsibility of the patient.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- **To pay their co-payment at the time of service**.
- To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier. If payment of that balance is not received within 30 days, **we will charge a $10 processing fee for each subsequently mailed statement.**
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- **To schedule all therapy appointments one week in advance** and to attend all appointments and follow home instruction. Please be aware your appointments may be scheduled any day of the week (Mon-Fri) and do not have to be set in a specific pattern. (i.e. Mon-Wed-Fri)
- To notify Rehab Plus of a cancellation 24 hours prior to your scheduled appointment or a **$25 cancellation fee** will be billed for each missed visit. You are subject to be discharged from our services after three missed appointments.
- To notify staff in advance of Physician appointments.

It is Rehab Plus Sport Therapy's Responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. Claims are filed twice per month (middle and end of month). Patient statements are sent out in the first week of each month. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.

Financial Policy Acknowledgement and Assignment of Benefits:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I authorize my insurance carrier(s) to make payment directly to Rehab Plus Sport Therapy (Jeff Kitchen, Inc.). Any payments made to me by third party payer services provided by Rehab Plus Sport Therapy (Jeff Kitchen, Inc.) will be immediately (within 5 days) transferred to Rehab Plus Sport Therapy (Jeff Kitchen, Inc.).

_____ _____/_____/_____

Patient or Responsible Party Signature *Date*

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt of HIPAA compliant *Notice of Privacy Practices*.

_____ _____/_____/_____

Patient or Responsible Party Signature *Date*

By signing above, you, as the patient or responsible party, agree to the terms and conditions listed under "Financial Policy Acknowledgement" and Assignment of Benefits". **Any unilateral alteration, strikeover or modification to the preprinted text or line entries of this document and legal agreement shall be of no effect whatsoever, and at Jeff Kitchen Inc.'s sole discretion, may render this document invalid.**