1803 Research Blvd.
Suite 101
Rockville, MD 20850

PATIENT REGISTRATION

Name:	Date:	DOB:

Email: Would you like to receive appointment reminders: Yes

Address:

Mobile: Home: Work:

HEALTH INSURANCE INFORMATION

Primary Insurance: Secondary Insurance

Patient is Subscriber/Policy Holder: Patient is Subscriber/Policy Holder:

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder:

Relationship to Patient: Date of Birth:

Social Security Number:

Address:

His or Her Employer:

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WORKER'S COMPENSATION / MOTOR VEHICLE ACCIDENT CLAIM INFORMATION

Insurance Company: Date of Injury:

Billing Address:

Adjuster/Case Manager: Claim #: State in which accident occurred:

Phone #: Fax #:

Attorney: Attorney's Phone #

PRIVACY PRACTICE

I certify that I have been made aware of Rebound Physical Therapy's Notice of Privacy Practices and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Rebound Physical Therapy's health care operations. The Notice also describes my rights and Rebound Physical Therapy's duties with respect to my protected health information. I understand that copies of the Notice of Privacy Practices are available in the registration areas of each facility and on Rebound Physical Therapy's web site at www.Reboundrockville.com.

Rebound Physical Therapy, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by asking for one at the time of my next appointment, or by accessing Rebound Physical Therapy's web site listed above to view the most current version.

Patient Name or Personal Representative:

Patient Signature or Personal Representative: Date:

Description of Personal Representative's Authority:

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s):

Relationship to Patient:

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CANCELLATION POLICY

We are so pleased that you chose our practice and we thank you for your dedication to your health and to your physical therapy program.

We have made it our priority to provide the highest level of care including, education and comprehensive exercise programs. We strive to provide this care within a convenient schedule that minimizes wait time.

As we go through this process together, we ask that you be aware of the importance of attending your scheduled sessions and our policies for canceling appointments.

- **Please be on time!** Your therapist expects you to be on time and plans your treatment accordingly. Lateness affects your progress (as you may miss vital parts of your treatment) and inconveniences the patients on the schedule after you.
- **If you must reschedule or cancel an appointment, please do so no later than 3:00 pm on the day before.** This will give our staff adequate time to fill your appointment slot as we often have a waiting list.
- **You will be charged a $40.00 cancellation fee** for any appointments cancelled the day of or after 3:00 pm on the previous day.
- **NO SHOWs are subject to the same $40.00 cancellation fee.**
- To alleviate confusion and mix-ups, please **provide** our front desk with **your email address and request emailed appointment reminders**. (Space has been provided on the front page of the registration packet for your email address. Please be sure to write legibly.)

I have read the terms of this Cancellation Policy and understand the importance of attending my physical therapy sessions.

Patient / Guardian Signature **Date**

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Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding Workers' Compensation, automobile, and other health care benefits (“Insurance Plan(s)”) to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Rebound Physical Therapy, LLC and each of the independent practitioners for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to Rebound Physical Therapy, LLC, and the independent practitioners for services rendered to me during the applicable periods of medical care.
2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider any service rendered during this admission a covered service or has not authorized this service, they will not pay for this service rendered during this visit. I agree to be fully responsible for payment to Rebound

Physical Therapy, LLC for any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.
3. **For Medicare Recipients Only** - In the case of Medicare Part B benefits, I request that payment of authorized Medicare benefits be made on my behalf to Rebound Physical Therapy, LLC and the independent practitioners for any services furnished to me by that practitioner. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Rebound Physical Therapy, LLC . I understand and agree this document will remain in effect for all future visits to Rebound Physical Therapy, LLC, unless specifically rescinded in writing by me.

Patient Signature: Date:

Relationship to Patient:

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MEDICAL QUESTIONNAIRE

For your Therapist to provide the most appropriate treatments and to identify any issues that may impact your treatment it is most important that the following information be as accurate as currently possible. If at any time additional information becomes available to you that may impact your care we ask that you inform your Therapist before continuing with treatments.

Patient Name: Date of Birth:

Patient Signature: Date:

Please answer the following: Height: Weight:

Please check which body region(s) you are seeking treatment for:

Laterality: ◯ Left ◯ Right ◯ Bilateral

☐ neck ☐ mid back ☐ low back ☐ shoulder ☐ elbow ☐ wrist ☐ hip ☐ knee ☐ ankle/foot ☐ other

How did the injury occur (what activity where you doing at the time)?:

Where did the injury occur?:

Have you ever had similar symptoms in the past? If yes, when?

Have you ever been a patient here before? If yes, for the ☐ same or ☐ different problem?

Have you had a surgical intervention for this problem? Date of surgery:

If yes, specify: Name of surgeon:

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days?

If yes, please describe:

Are you currently seeing any other health care provider for this condition?

If Yes, please list:

Have you previously seen any other health care provider for this problem? If yes, check all that apply:

☐ Physician ☐ Osteopath ☐ Podiatrist ☐ Orthopedist ☐ Neurologist

☐ Physical Therapist ☐ Chiropractor ☐ Other

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Please check those treatments listed below that have been tried in the past:

☐ None ☐ Chiropractic ☐ Braces ☐ Medications

☐ Physical Therapy ☐ Acupuncture ☐ Injections ☐ Tens Unit ☐ Other

If you have had therapy/chiro in the past, please indicate where, when, and how long you attended.

Have you recently had the following tests?
If yes, check all that apply/when was test performed:

	Special Test	Date	Area Tested		Special Test	Date	Area Tested
☐	x-rays			☐	MRI		
☐	CT Scan			☐	Bone Scan		
☐	Stress Test			☐	Myelogram		
☐	Echocardiogram			☐	EMG		
☐	EKG			☐	Blood Tests		
☐	Pulmonary Function Test			☐	Other		

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Have you noticed changes in the way you complete the activities below? Do you find them painful to complete? Or do they take longer to complete than you would like? Do you find that you do not feel confident while performing the activity? Do you now need assistance to complete the activity? Check ALL that apply.

Self Care

Activity	Fully Independent	Requires Assistance	Painful	Fatiguing	Other (explain)
Bathing/showering/washing	◯	◯	◯	◯	◯
Grooming/brushing	◯	◯	◯	◯	◯
Commode	◯	◯	◯	◯	◯
Sleep	◯	◯	◯	◯	◯
Driving	◯	◯	◯	◯	◯
Household chores	◯	◯	◯	◯	◯
Food Prep	◯	◯	◯	◯	◯
Laundry	◯	◯	◯	◯	◯
Dressing	◯	◯	◯	◯	◯
Care giving	◯	◯	◯	◯	◯
Volunteer work	◯	◯	◯	◯	◯
Communication	◯	◯	◯	◯	◯
Paying Bills	◯	◯	◯	◯	◯

Changing & Maintaining Body Position

Activity	Fully Independent	Requires Assistance	Painful	Fatiguing	Other (explain)
Remaining seated	◯	◯	◯	◯	◯
Remaining standing	◯	◯	◯	◯	◯
Squatting	◯	◯	◯	◯	◯
Kneeling	◯	◯	◯	◯	◯
Rolling over in bed	◯	◯	◯	◯	◯
Sitting to Standing	◯	◯	◯	◯	◯
Sitting in a car (airplane/bus/train)	◯	◯	◯	◯	◯

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Mobility & Walking					
Activity	**Fully Independent**	**Requires Assistance**	**Painful**	**Fatiguing**	**Other (explain)**
Walking - short distances	◯	◯	◯	◯	◯
Walking - long distances	◯	◯	◯	◯	◯
Running	◯	◯	◯	◯	◯
Jumping	◯	◯	◯	◯	◯
Walking on Tip toes	◯	◯	◯	◯	◯
Walking on uneven surfaces	◯	◯	◯	◯	◯
Stairs	◯	◯	◯	◯	◯
Escalator	◯	◯	◯	◯	◯
Crossing the street	◯	◯	◯	◯	◯
Crowds (bumping)	◯	◯	◯	◯	◯
Do You use an assistive device (i.e. cane, walker, scooter):					
Carrying, Moving & Handling					
Activity	**Fully Independent**	**Requires Assistance**	**Painful**	**Fatiguing**	**Other (explain)**
Shopping	◯	◯	◯	◯	◯
Carrying Packages	◯	◯	◯	◯	◯
Jumping	◯	◯	◯	◯	◯
Walking on Tip toes	◯	◯	◯	◯	◯
Walking on uneven surfaces	◯	◯	◯	◯	◯
Pulling objects	◯	◯	◯	◯	◯
Pushing objects	◯	◯	◯	◯	◯
Reaching	◯	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯	◯
Telephone	◯	◯	◯	◯	◯

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Is pain a symptom for which you are seeking treatment?: If yes:

Is the pain there all the time (constant)?:

Describe the character of your pain (i.e. sharp, dull, burning, aching, etc.):

Do you have radiating pain?

Have you recently noted:

- ☐ Weight loss/gain
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Fatigue
- ☐ Severe or frequent headaches
- ☐ Weakness
- ☐ Numbness or tingling
- ☐ Fever/chills/sweats
- ☐ Shortness of breath
- ☐ Bowel or Bladder leakage
- ☐ Chest pain
- ☐ Difficulty sleeping
- ☐ Swollen joints

Medication Record:

Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements).

If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation ☐ (Patient initials)

Medication	Dosage	Reason for taking

(Use the additional space on the last sheet if more space is needed.)

How many packs of cigarettes do you smoke a day?

How many days per week do you drink alcohol?

Have you ever had an allergic reaction to:

Lotion:	☐	Perfume:	☐	Gel :	☐	Latex:	☐	Adhesives:	☐

Are you pregnant? :

Do you have a pacemaker? :

REBOUND PHYSICAL THERAPY

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Do you have or have ever had any of the following?

- ☐ Cancer
  If so, what type?
  Date:
- ☐ Joint Replacement or Revision
  Specify Joint:
  Date:
- ☐ Other Neurological Disorder
  Please specify:
- ☐ Other Issues
  Please specify:
- ☐ Kidney Disease
- ☐ Epilepsy / Seizures
- ☐ Osteopenia / Osteoporosis
- ☐ Blood Clot
- ☐ Hearing Loss
- ☐ Vision Loss
- ☐ Depression
- ☐ Diabetes
- ☐ Circulation problems
- ☐ Asthma
- ☐ Emphysema/Bronchitis
- ☐ Thyroid problems
- ☐ Multiple Sclerosis
- ☐ HIV
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Hernia
- ☐ Anemia
- ☐ Incontinence
- ☐ Chemotherapy or Radiation
- ☐ High blood pressure
- ☐ Angina or Coronary Heart Disease
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Rheumatoid arthritis
- ☐ Other arthritic conditions
- ☐ Stroke/TIA

During the past month have you often been bothered by feeling down, depressed, or hopeless?

During the past month, have you often been bothered by little interest or pleasure in doing things?

Is this something with which you would like help?

At the present time, would you say your health is:

Where do you currently live (or intend to live) at the conclusion of your episode of therapy? Other

Who do you live with (or intend to live with) at the conclusion of your episode of therapy? Other

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?

Job Description(physical tasks, amount of sitting, lifting, computer work etc.):

Social Activities(physical tasks, amount of sitting, lifting, computer work etc.):

Have you missed work due to your condition/injury/problem? If Yes please indicate:

Last date worked due to this injury? Date returned to work after this injury?

Evaluating Physical Therapist Signature: Date:

- ☐ Margaret Conze, MS, PT 20498
- ☐ Abigail Sherman, PT, DPT 23182
- ☐ Emily J. Cameron, PT, DPT 27005

Clear Form