THE REBOUND GROUP, LLC PATIENT REGISTRATION FORM

PLEASE COMPLETE THE ENTIRE FORM

Have you ever undergone Physical Therapy treatment? Yes No Where:____________	Email:

PATIENT INFORMATION

Patient Name: (First, MI, Last)			SS#
Address:	City:	State:	Zip Code:

Home Phone #:	Cell Phone #:	Date of Birth:	Sex: M F	Status: Single Married Widowed Divorced

How did you here about The Rebound Group? Doctor Internet Advertisement Friend or previous patient Other ____________

Date of Injury / Onset Date:	Auto Accident? Yes No State______ Date: _____ / _____ / _____	Work Related? Yes No	Case Manager Name and Phone:

If Worker's Comp, was your accident with present employer?
Yes No (If NO, who was emplyer? ____________)
Occupation: ____________

Are you a Medicare Patient? **Yes** **No**
Are you currently receiving Home Health Services? **Yes** **No**
If YES, name of agency and type of Home Health Service you are receiving: ____________
If NO, have you received services in the last 30 days? Yes No Agency: ____________

PRIMARY INSURANCE INFORMATION

Insurance Company Name:	Policy/Claim #:	Group #:	
Insurance Address:	City:	State:	Zip Code:
Policy Holder Name:	Date of Birth:	Social Sercurity #:	
Insurance Company Phone #:	Policy Holder Work Phone #:	Patient Relationship to Policy Holder: Self Spouse Dependent Other	

SECONDARY INSURANCE INFORMATION

Insurance Company Name:	Policy/Claim #:	Group #:	
Insurance Address:	City:	State:	Zip Code:
Policy Holder Name: *(if different from above)*	Date of Birth: *(if different from above)*	Social Security #: *(if different from above)*	
Insurance Company Phone #:	Policy Holder Work Phone #:	Patient Relationship to Policy Holder: Self Spouse Dependent Other	

EMPLOYER INFORMATION

Employer Name:	Employer Phone #:	Employment Status: Retired FT PT Self-Emp. None	
Address:	City:	State:	Zip Code:

EMERGENCY CONTACT INFORMATION

Contact Name:	Contact Phone #:	Relationship to Patient: Sibling Spouse Parent Other

PHYSICIAN INFORMATION

Referring Physician:	Telephone #:

ATTORNEY INFORMATION (*IF APPLICABLE*)

Attorney Name:	Attorney Phone/Address:

The Rebound Group
IN-HOME PHYSICAL THERAPY

Serving Northern New Jersey
P: 201.345.7044 F: 201.345.7062
TheReboundGroup.com info@thereboundgroup.com

CONSENT FORM / RELEASE OF INFORMATION

Patient Name: ____________________________ Account #: ____________________

CONSENT TO EVALUATION AND TREATMENT

I do hereby consent to the evaluation and treatment by *The Rebound Group, LLC*. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION

I authorize *The Rebound Group, LLC* to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information to ____ (the name of patient's doctor and insurance company) for communication and care coordination on my behalf.

PRIVACY PRACTICES

I acknowledge receipt of the *The Rebound Group, LLC* Notice of Privacy Practice, which I have received at the time of this initial visit or previously.

ASSIGNMENT OF BENEFITS

I request that payment of Medicare/other insurance benefits be made on my behalf to *The Rebound Group, LLC* for any services furnished to me by *The Rebound Group, LLC*. I authorize *The Rebound Group, LLC* to release any information required to process this claim.

FINANCIAL AGREEMENT

The undersigned agrees, whether signing as agent or patient, that he/she individually obligates him/herself to pay for services rendered in accordance with the regular rates and terms of *The Rebound Group, LLC*. *The Rebound Group* will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

Medicare Patients: I understand that if I do not have supplemental insurance, I will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible.

The undersigned certifies that he/she has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

____ _____________________

Signature of Patient or Responsible Party Date

PHYSICAL THERAPY HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USE AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE IS POSTED ON THE FRONT DESK IN OUR OFFICE.

PLEASE REVIEW IT CAREFULLY

The Rebound Group, LLC is committed to maintaining and protecting the confidentiality of our patients' medical, personal, and sensitive information. We are required by federal and state law to protect the privacy of your individual identifiable health information and other personal information and send you this Notice about our policies, safeguards, and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notices, if we revise it.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
Payment: Your health information may be used to seek payment from your health plan or from other sources of coverage such an automobile insurer, or worker's compensation carrier. For example, your insurer may request and receive information on dates of service, the type of services provided, and the medical condition being treated.
Health Care Operation: Your health information may be used as necessary to support the day-to-day activities and management of **The Rebound Group, LLC.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
Lawsuits and Disputes: Your health information may be disclosed in response to a court or administrative order. For example, if you are involved in a lawsuit or dispute and **The Rebound Group** is served with a subpoena, warrant, summons, or other lawful process this office may be required by law to disclose your health information.
Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state Public Health Department.
Information About Treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.
Appointment Reminders: Your health information may be used by our staff to contact you regarding appointment openings and reminders. If you have any concerns about us leaving messages or information pertaining to appointment dates and times with other household members, please let us know. No confidential patient information will be left by phone.

Other uses and Disclosures Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific authorization. If you change your mind after authorizing a use or disclosure of your information you may submit in written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified **The Rebound Group, LLC.**

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policy and practices may be required by changes in federal and/or state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing to our office.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter discussing your concerns to:

The Rebound Group, LLC
233 Rock Road, #236
Glen Rock, NJ 07452
(201)345-7044

If you feel that your privacy rights have been violated, you may file a complaint with our office or the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

I ACKNOWLEDGE that I have received a copy of The Rebound Group's notice of privacy practices. I understand that this information describes how The Rebound Group may disclose and use my protected health information:

Patient's Name: ____ (please print)
Patient's Signature: ____
Date: ______________________

This Notice is effective on or after April 15, 2003

MEDICAL HISTORY FORM

The Rebound Group, LLC

Name:____ DOB:_______________

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

MEDICAL HISTORY: (please check any condition you have a history of. Items not checked are understood to be negative.)

___High Blood Pressure ___Abnormal Bleeding ___Bowel or Bladder Problems ___Heart Problem
___Asthma ___Autoimmune disorder ___Abnormal Heart Rate ___Emphysema
___Pacemaker ___Chronic Lung Problem ___Thyroid Problem (Hyper or Hypo) ___Arthritis
___Heart Palpitations ___Chronic Heartburn ___Cancer/tumors (where?_________) ___Angina (chest pain)
___History of Ulcers ___Shortness of breath ___High Cholesterol ___Seizures/Epilepsy
___Osteoporosis ___Night sweats ___Chronic heartburn/Intestinal upset ___Hearing problems
___Diabetes ___Dizziness ___Recent and sudden Weight Loss/Gain

Other: ____

Do you have a history of fractures? YES NO Where? _______________________________
Do you have a history of back/neck pain? YES NO When? _______________________________
Do you have any metal implants? YES NO Where? _______________________________
Do you smoke? YES NO How much per day? _______________________
Do you exercise regularly? YES NO How often? ____________________________
Do you have any known allergies? YES NO Please list ____________________________
Are you pregnant or suspect pregnancy? YES NO

MEDICATIONS: Please check if you are taking any of the following (Please list name of medications)

___Blood Pressure Medication ___Heart Medication ___Anti-coagulants (blood thinners)
_______________________ _______________________ _______________________
___Muscle Relaxants ___Pain Killers ___ Diabetes Medication (i.e.Insulin)
_______________________ _______________________ _______________________
___Steroids (Cortisone) ___ Anti-inflammatories ___Other Medications
_______________________ _______________________ _______________________

SURGERIES: Please list all surgeries, including date:

____
____

DIAGNOSTIC TESTS: Please check test(s) for current problem only.

( )X-rays ( )CT scan ( )MRI ( )Bone Scan ( )EMG ( )Bone Density
( )Blood Chemistry ( )Ultrasound ( )Other (please specify)______________________

Have you seen anyone else for your current problem?

( )Physician/MD ( )Chiropractor ( )Podiatrist ( )Orthopedic Surgeon ( )Dentist
( )Neurologist ( )Osteopath/DO ( )Physical Therapist Date:_________________

SYMPTOMS: In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities? YES NO
Do you have any weakness in your arms or legs? YES NO
Do you have any coordination or balance problems? YES NO
Do you have difficulty walking? YES NO

CHIEF COMPLAINT/ CURRENT CONDITIONS: Please describe:_____________________________________
____

Please rate your pain in this scale of 0-10 (please circle)(0 = No pain, 10 = Worst pain imaginable):
0 1 2 3 4 5 6 7 8 9 10

Briefly describe your goals with physical therapy treatment ______________________________________
____

I believe all information to be true and complete: Signature_____________________________Date:______________