Rapid Rehabilitation PC
Patients' choice for caring and personalized service

Medical History

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Next Doctor's Appointment:_____

Onset/ Injury Date: _____

Surgery Performed for condition and date:

_____

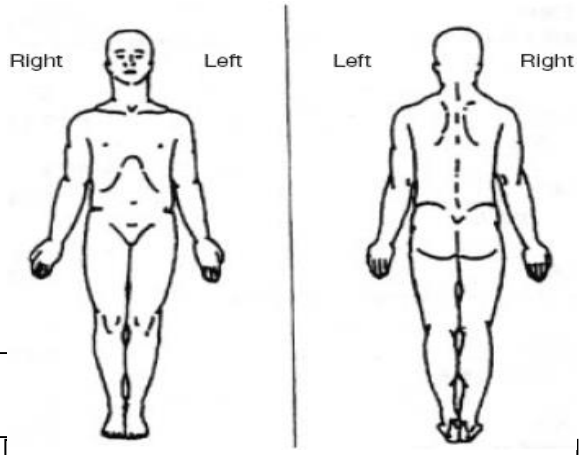
Previous hospitalization for this condition: ____ Yes ____ No

Admit date: _____ Discharge Date: _____

Chief Complaint / Reason for Visit: _____

_____

Hand Dominance: ____ Right ____ Left



Where are you experiencing pain, please mark the diagram.

		Check each that applies to the specific area								
	Please write the Specific Body part (Example: knee, wrist)	Burning	Sharp	Dull or Achy	Throbbing	Shooting	Numbness/ Tingling	Other (please write in the type of pain)	Is your Pain Constant or Intermittent (Please write C or I)	If the pain is Intermittent, What % of time is the pain present?
Neck										
Upper Extremity										
Lower extremity										
Trunk										
Low back/SI										

Current pain rating (0=none/ 10=severe): 0 1 2 3 4 5 6 7 8 9 10

In the past 3 days, please write a number 0-10): least pain _____ max pain _____

What relieves your symptoms? _____

What worsens your symptoms? _____

Describe previous treatment for this condition and whether it helped or worsened symptoms:

_____

_____

History of Home Health Care: ___ No ____ Yes; If so when and have you been discharged?

_____

History of Falls? ___ No ____ Yes; If so when and briefly describe what happened?

_____

Do you now or have you ever had any of the following (check all that Apply)?

__ Alzheimer's
__ Cardiovascular Disease
__ Cauda Equina Syndrome
__ Cerebral Vascular Accident
__ Current Infection
__ Diabetes Mellitus Type 1
__ Diabetes Mellitus Type 2
__ Fibromyalgia
__ Fracture or Suspected Fracture
__ High Blood Pressure
__ History of Cancer
__ Huntington's
__ Immunosuppression
__ Lupus
__ Muscular Dystrophy
__ Obesity
__ Osteoarthritis
__ Parkinson's
__ Rheumatoid Arthritis
__ Traumatic Brain Injury

Diagnostic Testing/ Imaging for your condition (check all that apply; If so, put date and location of the image):

__ CT Scan: Date_____ Imaging Location _____
__ MRI: Date _____ Imaging Location _____
__ X-ray: Date _____ Imaging Location _____

Are you currently taking any prescription or Non- prescription Medications (Please List Below)? If you have provided a list please check here: ____

List any other information that would assist us in your care:

_____

Based upon your awareness, what are your expectations/ goals while in this program?

_____

Is there anything else you would like to include or ask your therapist?

_____

_____

_____

_____ _____

Patient or Personal Representative Signature **Date**

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Patient Registration

Date: _____

Name (Last) _____ (First) _____ (M.I.) _____

Birth Date _____ Social Security _____ Age _____ Sex: M / F

Home Address _____

City _____ State _____ ZIP _____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Email _____ Preferred contact method (circle) Home Ph. /Cell Ph. /E-mail /Text

Emergency Contact _____ Relation _____ Phone _____

Status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Employment Full / Part-time / Not Working / Retired **Employer** _____

Referring Physician _____ Telephone _____

City/location of referring physician_____ Physician follow-up date:_____

Injury Type Work / Auto / Home / Other _____ State in which injury occurred _____

Area to be treated _____ First treatment date for this condition _____ Injury Date _____

Is an attorney involved? Yes / No Attorney Name _____

Address _____ Phone _____

Why did you choose Rapid Rehabilitation for your PT treatment? (Please list one primary reason)

❑ **Returning Patient** ❑ **Location** ❑ **Workshop** Name: _____

❑ **Doctor Referral** Doctor's Name: _____

❑ **Friend/Family Referral** Name: _____

❑ **Internet** (Circle which) Facebook / Yelp / Google / Our Website / Other _____

❑ **Phone Book** (Circle which) Shentel / Verizon / Community / Other _____

❑ **Other**: _____

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for **Rapid Rehabilitation Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. In conjunction with my care, I consent to allow the use of filming devices such as photographic images for purposes of enhancing my care and I consent to allow transmittal of such images to me and/or my treating physician via email or text.

☐ **Notice of Privacy Practices:** I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

☐ **Release of Medical Records:** I authorize release of Medical Records to Rapid Rehabilitation.

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Rapid Rehabilitation Physical Therapy** to treat the minor patient named in the attached forms while I am not present.

NEWSLETTER: In an ongoing effort to provide our patients with great customer service and the latest information regarding all of our client services you may periodically receive emails from our company and its affiliates. If you prefer NOT to get these emails please check the box below:

☐ **Opt out** of Email Newsletter

PR/SOCIAL MEDIA: Patients' names and photographic images may occasionally be used by Rapid Rehabilitation on its PR/social media activities, including, but not limited to Facebook and its website. If you prefer NOT to be included in these activities, please check the box below:

☐ **Opt out** of Social Media

Signature of Patient or Parent/ Guardian: _____ Date ____/____/_____

Please provide your insurance information

Primary Insurance _____

ID number _____ Group number _____

Subscriber Name_____ Social Sec. #_____ D.O.B. _____

Subscriber Address _____

Relation to Patient Self/ Spouse / Child / Other

Secondary Insurance _____

ID number _____ Group number _____

Subscriber Name_____ Social Sec. #_____ D.O.B. _____

Subscriber Address _____

Insurance Card Copied yes ___ no___

Please select one of the following billing options: (Health, Workers Compensation, Self-pay)

❑ **Bill my health insurance**

Assignment of Insurance Benefits: I hereby authorize **Rapid Rehabilitation Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

☐ **Medicare authorization (required for all Medicare and/or Humana patients):** I request that payment of authorized Medicare benefits be made to Rapid Rehabilitation for any service furnished to me by that physician. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

By signing below you indicate that you are aware of and will abide by the following:

- Estimated patient responsibility will be collected before the start of the visit.
- That you, the patient, not the insurance company, are ultimately responsible for any unpaid balances.

Signature of Patient:_____ Date: ____/____/_____

Signature of Parent/Guardian (if applicable)_____

☐ **Bill my worker's compensation**

WORKERS' COMPENSATION CLAIMS (if applicable): If your claim Workers' Comp benefits are denied, you may be held responsible for the total amount of charges for services rendered.

Workers Compensation Claim #_____
Adjuster Name_____
Adjuster Phone Number_____

Patient Signature:_____ Date: ____/____/_____

Signature of Parent/Guardian (if applicable)_____

☐ **Do not bill my health insurance**

By signing below you indicate that you are aware of and will abide by the following:

- You will pay your prompt pay rate of $110 per visit at the time of service (unless other arrangements are made).
- An itemized HCFA billing ticket will not be available if you select this option. Only a standard receipt showing your payment for service.

Patient Signature:_____ Date: ____/____/_____

Signature of Parent/Guardian (if applicable)_____

Patient Financial Agreement

Keeping the lines of communication open with all of our patients on all matters is a key focus of Rapid Rehabilitation. The following are the financial policies and expectations for our office. Please read carefully, and if you have any questions, please do not hesitate to ask a member of our office staff for clarification.

- Upon arrival to our office, please check in with the front desk and inform them of any changes to your insurance coverage, contact information, or payment information.

- As a courtesy we will call your insurance company prior to your first visit, as long as we were given this information, so that you will know what your financial obligations will be for your physical therapy. Physical therapists are specialists and your insurance company will process your visits as such. So if you have different copays for PCP vs specialist you will have the specialist copay. Unlike your PCP we only bill an office visit on your evaluation and thereafter you would be charged based on what procedures were performed during that visit so you might see multiple codes on your statement or explanation of benefits.

- **FINANCIAL POLICY**: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. Per the contractual obligations we have with your insurance company, we are required to collect all payments at the time of treatment unless payment arrangements are made prior to your treatments. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us.

- **All visit payments are due before the start of your treatment each visit.**
  We do our best to estimate the amount that your particular insurance plan will apply to your deductible, co-pay or co-insurance, or hold you, the patient, responsible for each visit. If your insurance company deems you responsible for an amount that differs from what we estimated, this will be considered as the patient's responsibility and will be billed to the patient. If you wish to set up an auto-pay arrangement to have a card regularly charged for your visits, please speak with our front desk administrator.

- There will be a $35 fee charged for all checks returned for insufficient funds.

- You will receive a statement in the mail for any unpaid balance due on your account. Failure to make a payment within 60 days of the billing cycle will result in the collection process to begin. Should you fail to make payment on your account the matter may be settled in District Court with all expenses added to your bill. If this account is turned over to our collection agency, 33 1/3% of the account balance will be added for collection cost.

- There is a $10 admin fee for all copies of records plus 50 cents a page.

I have read and understand this patient financial agreement. I agree to comply and accept responsibility to the terms outlined above.

Patient Name:_____

Signature:_____ Date:_____

Guarantor/Parent/Guardian Information (if applicable)

Name: _____ D.O.B _____

Address: _____

Signature: _____Date: _____

ATTENDANCE POLICY

Rapid Rehabilitation strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assuring continuity of treatment. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. The following are our policies regarding cancellations and no shows.

- We require **48 hour notice** in the event of a cancellation. It is your responsibility when you call in to have an alternative time in mind that will ensure you get the full determined number of treatments that week whenever possible.
- If voicemail is left during non-business hours, the $40 cancellation fee will be applied to any cancelled appointments without 48 hour notice.
- There is a **$40 charge** for a cancellation without proper notice. This charge will not be covered by your insurance/third party payer, and **you** are responsible for payment of the cancellation fee. The fee will be donated to our local Free Medical Clinic.
- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is appropriately reported to your Case Manager & Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you do rearrange your appointment. All of our therapists are experienced professionals and they will study your patient chart, so you will be in good hands.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a good reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is a legitimate reason not to come in: a) if you're in pain, come in so your physical therapist can assess your condition and assist in reducing your symptoms, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself, etc.
- Failure to show up for an appointment ("NO-SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.
- In cases of inclement weather, please call our office for closing and delays.

When you don't show as scheduled, three people are hurt: you, because you don't get the treatment you need as determined by the doctor and/or PT; the therapist who scheduled the time for you, and your treatment; and another patient who could have been scheduled for treatment if you had given proper notice.

Patient Signature **Date**