rebalance
PHYSICAL THERAPY

Patient Registration Form

Legal Name: Last - First _____

Conversational Name If Different: _____

Date of Birth: _____ **Age:**_____ **Pronouns:** She/Her, He/Him, They/Them, Zie/Zim

Birth Sex: M / F / I **Gender Identity if Different:**_____

Cell Phone:_____**Text:** Y / N **Home Phone:**_____

E-mail Address:_____**Work Phone:**_____

Preferred contact method: Home / Cell / Work Phone / Email (circle one)

Street Address:_____ **Apt#**_____

City:_____**State:**_____**Zip:**_____**Country:**_____

Billing Address Same as above? Yes / No *If no, please provide full billing address below:*
*BILLING Street Address:*_____ *Apt#*_____

*City:*_____*State:*_____*Zip:*_____*Country:*_____

Emergency Contact:_____ **Relationship:**_____ **Phone:**_____

Diagnosis:_____

Referring physician:_____ **RX on file: Y / N**
(if applicable)
Address: _____**Phone:**_____
_____**Fax:**_____

**** Is Medicare your primary insurance? (or Medicare replacement/supplement): Yes / No**

Would you like to be added to our mailing list? Yes / No (Please Circle One)

How did you hear about us? _____Referred by:_____

Have you visited our website? Yes/No (circle one)

Do you utilize social networking sites? If so, which?_____

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Health History

Name_____

Date of Last Physical Exam_____
Tests performed_____
On disability or leave?_____Activity restrictions?_____
Mental Health: Current level stress High /Med / Low
Current psych therapy? Y/N
Activity/Exercise: (circle one) None 1-2 days/week 3-4 days/week 5+days
Describe_____

Have you ever had any of the following conditions or diagnosis? Circle all that apply

Cancer	Stroke	Emphysema
Heart Problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple Sclerosis	Allergies (list below)
Ankle Swelling	Head injury	Latex Sensitivity
Anemia	Osteoporosis	Hypo/Hyperthyroid
Low Back Pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone Pain	Fibromyalgia	Diabetes
Alcoholism/Drug Problem	Arthritic conditions	Kidney Disease
Childhood Bladder Problems	Stress Fracture	Irritable Bowel
Depression	Rheumatoid Arthritis	Hepatitis/HIV/AIDS
Anorexia/Bulimia	Joint Replacement	Sexually Transmitted Disease
Smoking history	Bone Fracture	Physical/Sexual Abuse
Vision/eye problems	Sports Injury	Raynaud's
Hearing loss/problems	TMJ/neck pain	Pelvic Pain

Other/Describe_____
_____

Surgical/Procedure History

Y/N	Surgery for back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (female)

Y/N	Childbirth vaginal deliveries #_	Y/N	Vaginal Dryness
Y/N	Episiotomy #_	Y/N	Painful periods
Y/N	C-Section #_____	Y/N	Menopause-when?_____
Y/N	Difficult Childbirth #_	Y/N	Painful Vaginal Penetration
Y/N	Prolapse or Organ falling out	Y/N	Pelvic Pain

Y/N Other/Describe_____

Medical History (male)

Y/N Prostate disorders
Y/N Shy bladder
Y/N Pelvic Pain
Y/N Other/Describe_____

Y/N Erectile Dysfunction
Y/N Painful Ejaculation

Medications-pills, injection, patch, over the counter	Start date	Reason for taking

1. Describe the current problem that brought you here: _____
_____

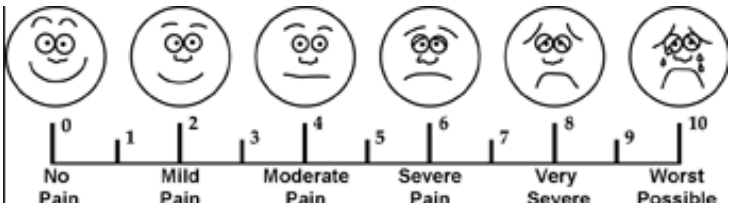
2. When did your problems first begin? _____ months ago / _____years ago

3. Was your first episode of the problem related to a specific incident? **Yes / No**
If so, please describe and specify date _____
_____

4. Since that time is it (circle): staying the same / getting worse / getting better
Describe: _____
_____

5a. If pain is present, rate pain on a 0-10 scale, 10 being the worst. _____

5.

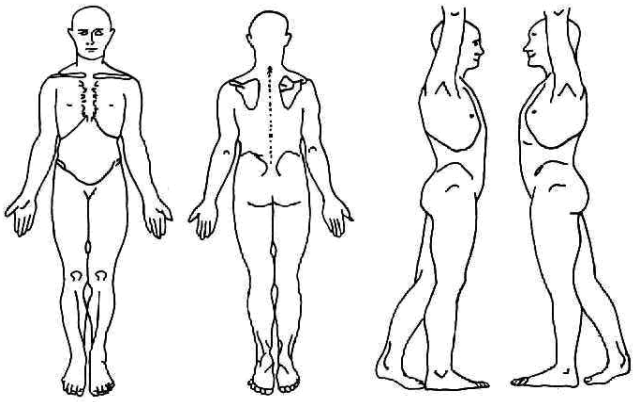


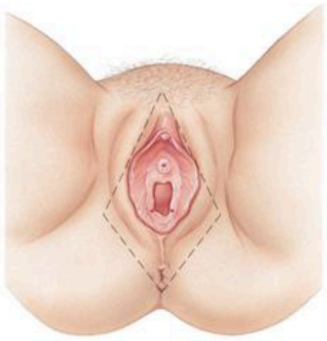
5b. Circle the type of pain you are having. You can circle more than one.

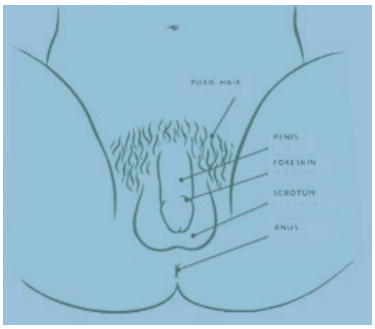
Throbbing	Shooting	Stabbing	Sharp	Cramping	Gnawing
Hot-burning	Aching	Heavy	Tender	Splitting	Tiring
Sickening	Fearful	Punishing-Cruel			

Other_____

5c. Use the body charts below to mark or shade the area where your pain is located.







6. Describe any previous treatment/exercises _____
_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply:

_____Sitting greater than____minutes	_____With cough/sneeze/straining
_____Walking greater than ___minutes	_____With laughing/yelling
_____Standing greater than____minutes	_____With lifting/bending
_____Changing positions (i.e. sit to stand)	_____With cold weather
_____Light activity (light housework)	_____With triggers
_____Vigorous activity/exercise	_____With nervousness/anxiety
_____Sexual activity	_____No activity affects problem

_____Other, please list_____

8. What relieves your symptoms? _____
_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify: _____
Diet/Fluid Intake, specify: _____
Physical activity, specify: _____
Work, specify: _____
Other, please list: _____

10. Rate the severity of this problem from 0-10 with 0 being no problem and 10 being the worst: _____
11. What are your treatment goals/concerns? _____
_____

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Treatment Consent Form

I understand that I am a patient of Rebalance Physical Therapy a practice at either 319 Price Ave Narberth, PA 19072 or 1601 Walnut St, Suite 606, Philadelphia PA 19102. My care is exclusively the responsibility of Rebalance Physical Therapy and not of any other practitioners who also may practice at this location.

Cooperation with Treatment
In order for the manual physical therapy to be effective, I will come to the scheduled appointments and perform the individually designed therapeutic exercise program to the best of my ability.

Informed consent for treatment
I understand that I will receive information at the initial visit concerning manual treatment care and other lifestyle changes that may improve my condition.

Potential Risks
I may experience a temporary increase in my current level of pain or discomfort after initial treatment.

Potential Benefits
I may experience an improvement in my symptoms and an increase in my ability to perform daily activities: I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I will gain a greater knowledge about my condition and the resources available to me to manage it.

_____ _____
Print Name Date

_____
Signature

if patient is under 18:
Authorized Representative/Guardian Signature:_____ Date_____

Rebalance Physical Therapy Cancellation Policy

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a 'no show' or failure to give a 24-hour notice of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Please be aware that insurance companies will not cover cancellations charges.

If you are unable to keep your appointment, please notify us as soon as possible. 24 hours advanced notice is required to avoid charges. We understand that extenuating circumstances may prevent you from providing 24 hours advanced notice, and we will evaluate these situations on a case-by-case basis. Furthermore, Rebalance reserves the right to cancel any additional visits you may be scheduled for after late cancelling or no-showing two or more consecutive visits or after late cancelling/no-showing your initial evaluation appointment. We will provide notification of this.

Credit Card Authorization:

I, _____ ,authorize Rebalance Physical Therapy to charge the full session fee to the credit card below in the event that I fail to give at least 24 hours notice of cancellation of a scheduled appointment.

Card Type (circle one) Visa Master Card

Card Number: _____ exp._____

Name as printed on card:_____

****** If above card is different from what was provided to us at the time of scheduling, it is your responsibility to notify our front desk so that they may change what is already on file. Thank you!**

I have read the above fee agreement conditions.

Authorized cardholder signature:_____

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E-Mail Consent Form

Patients/Clients frequently request that we communicate with them by email. Rebalance Physical Therapy respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email can be inherently insecure as a method of communication, we will only communicate with you by email with your written consent at the email address you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email you are consenting to email communications that may not be encrypted. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through email. Rebalance Physical Therapy will not be responsible for any privacy or security breaches that may occur through email communications that you have consented to.

You may choose to limit the type of email communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email.

- ☐ I do not consent to any email communication.
- ☐ I consent to receiving email communication about the scheduling of appointments or other communications that do not reveal my protected health information only.
- ☐ I consent to all communication by email, including but not limited to communication about my medical condition and advice from my health care providers.

E-mail address you are consenting to communicate through: _____

Patient Signature: _____ Date_____

Authorized Representative/Guardian Signature:_____ Date_____

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Acknowledgement of Receipt of Notice of Privacy Practice of Rebalance Physical Therapy

319 Price Avenue, Narberth, PA 19072
1601 Walnut Street Suite 606, Philadelphia PA 19102

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I understand that this information can be used to:
-Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
-Obtain payment from third party payers.
-Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been informed of Rebalance Physical Therapy's Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information.
I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this organization restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I allow the following health care professionals to receive information and communicate with my physical therapist at Rebalance Physical Therapy:

1. **Name**_____**Ph:**_____**Address**_____
2. **Name**_____**Ph:**_____**Address**_____
3. **Name**_____**Ph:**_____**Address**_____
4. **Name**_____**Ph:**_____**Address**_____

Patient Name (print): _____

Signature:_____

Date:_____

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Payment Agreement

Thank you for choosing Rebalance Physical Therapy, Inc. as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Medicare Policy.** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since our services are not designed to meet Medicare's covered benefit requirements and we are not Medicare enrolled providers, our services will not be covered (paid) in full or in part, by Medicare (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider. We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. By choosing to receive our services after being fully informed of these facts, you are agreeing to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled provider. You also understand that since we are not enrolled Medicare providers and our services do not meet the technical requirements for Medicare covered benefits, our services are *not* subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare or your Medicare Advantage Plan for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and

claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare, unless we have agreed to accept assignment and await payment from your health insurance insurer (we do not accept assignment from Medicare). If you want your records disclosed to any third party in the future, you will need to obtain and sign our Disclosure to Release Protected Health Information form before we will disclose your health information.

- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. Upon receiving a denial for payment, in whole or in part, we will bill you for our services and you will be personally responsible for whatever fees your health plan does not cover. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **Late Payment Interest.** Unless prohibited by applicable law, interest in the amount of 1.5% per month (18% per year) may be added to your bill for any and all claims that are not paid within thirty (30) days of the invoice or statement date. You agree to be personally responsible for paying such interest unless the responsible Payor is required to pay such interest under federal, state or other applicable laws.
- **Medical Records Copies:** We charge for copies of medical records when requested from patients for personal reasons. The patient is responsible for all copy charges. Copy charges for small records are $25.00 dollars and $50.00 dollars for large records. We will provide records directly to insurance and medical personal as needed. Copies from legal representatives will need to be requested directly from their offices and an invoice will be provided for our services.
- **Collections.** You understand that we are not required to obtain your my written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

X _____ Date: _____
Signature of Patient and/or Guardian

X _____ Date: _____
Witness

A photocopy of this agreement is to be considered valid, the same as if it was the original