Gold Rehab Services
PHYSICAL THERAPY

Patient Information			
Last Name	First Name	MI	Date of Birth
Occupation	Marital Status ☐ S ☐ M ☐ W ☐ O	Sex ☐ M ☐ F ☐ O	
Address	City	State	Zip
Home Number	Mobile Number	Email	
Employer Name (Required for Worker's Comp Patients)	Employer's Phone Number	Employer's Contact Name	
Preferred Method of Contact: ☐ Home Number ☐ Mobile Number ☐ Email			
Consent to Email Communication: I agree to receive email communication from **Gold Rehab Services** pertaining to appointment reminders, statements, and other account information, as well as clinic news and updates. _____ **Initials**			

Emergency Contact		
Primary Emergency Contact Name	Phone Number	Relation to Patient
Secondary Emergency Contact Name	Phone Number	Relation to Patient

Referral Information		
Referring Physician Name		
Referring Physician Phone	Referring Physician Fax	
Patient or Parent/Guardian Signature **X**		**Date**

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Insurance Information		
Primary Insurance Name		Primary Insurance Phone Number
Member/Subscriber ID Number	Group Number	Relation to Patient
Name of Insured (If other than patient)		Date of Birth of Insured (If other than patient)
Secondary Insurance Name		Secondary Insurance Phone Number
Member/Subscriber ID Number	Group Number	Relation to Patient
Name of Insured (If other than patient)		Date of Birth of Insured (If other than patient)

Worker's Comp Complete this section if your injury/condition is related to a work injury. N/A ☐	
Worker's Comp Insurance Carrier	Worker's Comp Insurance Carrier Phone Number
Claim Number	Accident Date
Adjustor's Name	Adjustor's Phone Number

Auto Insurance Complete this section if your injury/condition is related to an auto accident. N/A ☐	
Auto Insurance Carrier	Auto Insurance Carrier Phone Number
Claim Number	Accident Date
Adjustor's Name	Adjustor's Phone Number

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Medical History Form

Name_____ Date Symptoms Began_____

In a few words, describe your symptoms _____

_____

Are your symptoms related to an accident? ☐ Y ☐ N If yes, please describe the accident_____

_____

_____

Did your illness/injury require surgery? ☐ Y ☐ N If yes, please provide the date of surgery_____

Have you ever been diagnosed with any of the following conditions?
Check all that apply:

☐ Arthritis	☐ Headaches/Migraines	☐ Paralysis
☐ Asthma	☐ Syncope	☐ Muscle Weakness
☐ Hypertension	☐ Dizziness	☐ Pregnancy _____weeks
☐ Fractures	☐ Heart Disease	☐ Herniated disc
☐ Seizures	☐ Osteoporosis	☐ Scoliosis
☐ Diabetes	☐ Pacemaker Implantation	☐ Cancer Type_____

Other conditions _____

Did you have any diagnostic testing for your current condition?

☐ X-rays ☐ CT Scan ☐ Bone Scan ☐ EMG ☐ Nerve Conduction Study ☐ MRI ☐ Other

Rate your pain intensity on a scale of 0-10. (0 being no pain)
Rate your current and prior level of function on a scale of 0% to 100%. (100% being you are fully functional)

Pain
Current ____/10
At best ____/10
At worst ____/10

Function
Current_____/Prior_____

What are your primary goals for physical therapy? _____

_____

_____

Patient or Parent/Guardian Signature	**Date**
X	

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Financial and Cancellation Policy

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Please note, all payments for deductibles, co-insurances, and/or co-payments, as well as payment for self-pay services, are due at time of service. All patients are required to keep a debit/credit or FSA/HAS account on file.

Note that payments made at time of service are for an estimated amount based on the benefit information provided by your insurance company, and not the exact amount you will owe for any given date of service. Final dollar amount due for services will be determined after your insurance processes your claim. (This statement is not applicable to self-pay patients).

The clinic accepts cash, personal checks (in-state only), VISA, MasterCard, and Discover. There is a $25.00 service charge for returned checks.

Patients with an outstanding balance 60 days or older may be forwarded to a third-party collection agency.

INSURANCE

Our office will check your benefits as a courtesy to you and provide this information on or before your first appointment, when possible. The benefit information we will provide is only a quote of benefits, so it is not a guarantee that we will receive payment from your insurance company for services rendered. The actual benefit for services provided will be determined by your insurance once they receive your claim.

We bill your insurance companies as a courtesy to you. You are expected to pay your deductible, co-insurance, and/or co-payment at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. Please note, even though we will bill your insurance carrier, you are still ultimately responsible for payment of all services rendered, whether by you or your insurance company.

CANCELLATION AND NO-SHOW POLICY

If you are unable to keep your scheduled appointment, please provide 24-hour notice. Any late cancellations will incur a $50.00 fee. Failure to show for an appointment will result in a $75 no-show fee. As a reminder, cancellation and no-show fees are not covered by insurance.

For worker's compensation patients, if you fail to keep your scheduled appointments, your case manager will be notified.

Reassignment of Benefits

I authorize payment of medical benefits to **Gold Rehab Reservices** for services rendered. Gold Rehab Services will make reasonable efforts to collect insurance proceeds by completing insurance claims and sending them to the insurance company. Completion of such claims and/or acceptance of assignment of insurance benefits does not relive the undersigned of the obligation to pay the owed for services rendered.

By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.

Patient or Parent/Guardian Name:	**Date**
Patient or Parent/Guardian Signature X	

Consent to Physical Therapy Evaluation and Treatment

Physical Therapy is a patient care service that is provided to manage and treat a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to prevent and treat disease, injury, and disability through examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization of joints and soft tissues, manipulation, exercises, patient education, and physical agents to help the patient reach their greatest potential within their capabilities, to accelerate convalescence, and to reduce the length of functional recovery. All procedures will be thoroughly explained to you as needed and requested before you are asked to perform or participate in them.

Response to physical therapy intervention varies from person to person, hence it is not possible to accurately predict your response to a specific procedure, exercise protocol, or modality. **Gold Rehab Services** does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition for which you are seeking treatment. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort, pain, or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the potential risks involved in physical therapy. I understand that the success of my treatment depends on my ability and willingness to cooperate and participate in all physical therapy procedures and comply with the established plan of care.

Notice of Privacy Practices

I certify that I have received a copy of the Notice of Privacy Practices of **Gold Rehab Services**. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of **Gold Rehab Services** health care operations. The Notice of Privacy Practices also describes my rights and **Gold Rehab Services**' duties with respect to my protected health information. The Notice of Privacy Practices is also available at the clinic location and on the **Gold Rehab Services** website at www.goldrehabservices.com. **Gold Rehab Services** 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 calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the **Gold Rehab Services** website.

By my signature below, I certify that I have read, understand, and fully agree to the statements in this section and sign below freely and voluntarily.

Patient or Parent/Guardian Name:	**Date**
Patient or Parent/Guardian Signature X	