Thank you for choosing Real Rehab Sports + Physical Therapy. We would like to welcome you as a new patient. Our staff wants to ensure that your first visit goes smoothly and that all of your questions are addressed. To assist us in better serving you, please take a moment to review the following information:

Please arrive 15 minutes early to your scheduled appointment in order to complete the intake and check-in process. This will help to ensure your appointment begins on time. If you arrive 15 minutes or later for your scheduled appointment, we will need to reschedule the appointment out of courtesy for other patients and the clinicians. Please bring the following with items with you:

- All the completed intake and medical history forms
- Your doctor's written prescription, if required by your insurance
- Any Image and/or Surgery Reports related to your Injury/Condition
- Your insurance card and a form of photo ID. We will need to scan a copy of these items into your chart to ensure we collect all necessary information to bill your insurance company.
- Co-payment if applicable, as these are due at the time of service. Please note we accept cash, check and Mastercard/Visa.

Your evaluation will take 55 minutes and any miscellaneous time spent with administrative issues can take up to an additional 15 minutes (scheduling, payment, completion of paperwork, etc.). All subsequent visits will last 55 minutes. Your initial evaluation will consist of an interview and a physical examination performed by a licensed physical therapist. At the completion of your evaluation, the therapist will discuss the clinical findings with you and outline a treatment plan. Once a treatment plan has been established, the therapist will discuss incorporating a home exercise program to supplement your visits. Please wear or bring comfortable, loose fitting clothing that will allow the therapist to expose the affected regions of the body:

- If your care is regarding your lower body or back, please wear or bring shorts.
- If your care is regarding your upper body or back, please wear or bring a tank top or other appropriate clothing which reveals the body part being treated.

Real Rehab Sports and Physical Therapy offers Wellness and Performance services in addition to traditional physical therapy to raise the bar when it comes to play. Check out our website, www.realrehab.com or ask a member of our team about our Wellness and Performance Services. These services include Bike Fitting, Video Gait Analysis and Metabolic Efficiency Testing.

Thank you in assisting us in making your visit to Real Rehab a positive experience. Should you have any questions regarding your appointment, please do not hesitate to contact one of our Front Office Coordinators at (206) 706-7500. If it is necessary to cancel an appointment, please call to reschedule at least 24 hours prior to your scheduled appointment. We look forward to working with you and assisting you in REACHING YOUR PEAK!

PLEASE SEE OTHER SIDE TO REVIEW OUR FINANCIAL POLICY

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Real Rehab Sports and Physical Therapy. We are honored by your choice and are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our client financial policies.

Patient Financial Responsibility

- The client (or client's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the client is required to provide the most correct and updated information regarding insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- Clients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service, and for your convenience, we accept cash, check and most major credit cards.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Clients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned checks.
  - Charge for missed appointments without 24 business hour advance notice (refer to cancellation policy for details (refer to cancellation policy for specifics).
  - We will bill auto/accident claims; however, we do not await settlement for payment coverage. The client is responsible for any incurred charges.

By my signature below, I hereby authorize assignment of financial benefits directly to Real Rehab Sports and Physical Therapy. I understand that I am financially responsible for any charges not covered by this assignment.

Client Name:____Date: ____________________

Client/Guardian Signature:____________________________________Date: ____________________

Real Rehab
SPORTS + PHYSICAL THERAPY

Intake Information Form

How did you find out about our facility?

☐ MD ☐ Friend ☐ Previous Patient ☐ Insurance Carrier ☐ Other:______________________________

Patient Information			**Responsible Party/Billing**		
Last	First	M.	Last	First	M.
Address			Address		
City	State	Zip	City	State	Zip
Home Phone		Cell Phone	Home Phone	Cell Phone Sex M ☐ F ☐	
Work Phone	Employer		Work Phone		
Date of Birth	Age		Employer		
Emergency Contact	Phone Number		Date of Birth	Age	
Spouse's Name	Work Phone		Spouse's Name	Work Phone	

Email Address: ______________________________

☐ ***Please send me information on your upcoming events and Specialty Services***

Preferred Appointment Reminders: ☐ Phone ☐ Text ☐ Email

Referring Physician	Phone #	Primary Care Physician	Phone #

Patient/Guardian Signature:______________________________ Date______________

****I hereby Authorize Real Rehab Sports + Physical Therapy Access to my Medical Records for the Above Physician/'s***

Are current symptoms related to: ☐ Auto Accident; If so, has the accident been reported? ☐ Yes ☐ No State of Accident __________

☐ Work Injury; If so, is there a case manager involved? ☐ Yes ☐ No Date of Accident: __________

Case Manager Name:______________________________ Phone #______________Fax # ______________

Employer Contact/Title:______________________________ Phone #______________Fax # ______________

Current Work Status: ☐ Full Duty ☐ Limited Duty ☐ Not Working

Diagnosis (es):______________________________Date of last MD Appt:________Date of Next MD Appt:__________

Date of Onset/Injury:______________Rx Date______________ Surgery: ☐ Yes ☐ No Date of Surgery:______________

Have you had physical therapy, occupational therapy, speech therapy, chiro care, etc. this benefit year? ☐Yes If so, where____________ ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,____(printed name of patient or personal representative) acknowledge that I have received a copy of the Notice of Privacy Practices of **Real Rehab Sports + Physical Therapy** for (check one)______me______specify name of individual [please print clearly] and agree to the liability limitations explained therein:______________________________ .

____ ________________

Signature of Patient or Personal Representative **Date**

____ ________________

Print Name **Relationship to patient (not self)**

CONSENT TO TREAT

The patient authorizes the Physical, Occupational, and/or Speech Therapist to examine and treat the condition as he/she deems appropriate through the use of physical/occupational, and/or speech therapy measures, and the patient gives authorization for these procedures to be performed.

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Physical, Occupational, and/or Speech Therapist. The patient will not hold the Physical, Occupational, and/or Speech Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient shall be advised if Real Rehab Sports + Physical Therapy proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

I have read (or have had read to me) the above information and understand the content.

____ ________________

Patient (or Guardian) Signature **Date**

____ ________________

Witness Signature (If you are unable to Sign) **Date**

Real Rehab Sports + Physical and Physical Therapy Late Cancellation/Missed Appointment Policy

Missed appointments and those canceled less than **24** hours in advance impact our ability to provide healthcare to you and others that are in need of our care. We provide reminder calls and/or emails prior to your appointment but this does not excuse you from any missed appointments. You are ultimately responsible for any and all of the appointments that you have scheduled with us.

In the event you need to cancel an appointment, we require at least 24 business hours' notice (Monday appointments MUST be canceled no later than 3pm of the prior Friday.). Any appointments that are either canceled less than **24** hours in advance or are missed will result in a ***$125*** fee that will be charged directly to your account. ***A pattern of missed appointments may also result in our no longer being able to provide you further care at our facility.***

We realize that emergencies do occur – late cancellation due to illness known or possible exposure to COVID-19 and family emergencies are excluded from this policy.

I, the undersigned, have been informed about the Cancellation/Missed Appointment Policy here at Real Rehab Sports and Physical Therapy.

____ ________________

Patient (or Guardian) Signature Date

Real Rehab
SPORTS + PHYSICAL THERAPY

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 1)

Patient Name:____ **DOB:**_____________**Date of Eval:** _____________

Sex Assigned at Birth:________________________Current Gender Identity: ____

MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

Describe the current problem that brings you here today:____

When did your symptoms start?____**What Side of Your Body?**_____________________

Are your symptoms: ☐ **Improving** ☐ **Getting Worse** ☐ **Staying the Same**

Have you had any testing? ☐ **X-rays** ☐ **MRI** ☐ **EMG/ Nerve Conduction Test** ☐ **CT Scan** ☐ **Other :**____________________

Results (please provide report, or contact information for report): ____

Have you ever had these symptoms before? ☐ **Yes** ☐ **No** **Description:**__________________________

Did you have surgery for this issue? ☐ **Yes** ☐ **No** **Date of Surgery:** _______________________________________

Describe any treatments you have received for this issue, and subsequent benefits or effects:

____

____

Name of Physician:__________________________________**Date of next Doctor's appointment:** _____________________

Since the onset of your symptoms have you had: (check all that apply)?

- ☐ Fever/Chills/Sweats
- ☐ Any difficulty with control of bowel or bladder function
- ☐ Nausea or Vomiting
- ☐ Significant, unexplained change in body weight (gain/loss)
- ☐ Any numbness in the genital or anal area
- ☐ Unexplained Fatigue
- ☐ Pain that does not change with rest, activity, or position change
- ☐ Difficulty with Walking Balance/Falls
- ☐ Dizziness/Lightheadedness/Fainting Attacks
- ☐ Problems with Vision/Hearing
- ☐ Numbness
- ☐ Shortness of Breath
- ☐ Headaches
- ☐ Difficulty swallowing
- ☐ Pregnancy: How Many Children?_____; if currently pregnant, how many weeks? _________

PREVIOUS MEDICAL HISTORY

Have you EVER been diagnosed with, or suspected of having, any of the following conditions, please check ALL that apply and supply details as able:

- ☐ Cancer (type)______________________
- ☐ Heart Problems
- ☐ Chest Pain/Angina
- ☐ High Blood Pressure
- ☐ Circulation Problems
- ☐ Blood Clots
- ☐ Stroke
- ☐ Depression
- ☐ Anemia
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Infectious Disease (i.e., hepatitis, tuberculosis, etc.)
- ☐ Bone or Joint Infection
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Other Arthritic Condition
- ☐ Bladder/Urinary Tract Infection
- ☐ Pelvic Inflammatory Disease/Endometriosis
- ☐ Kidney Problem/Infection
- ☐ Thyroid Problems
- ☐ Blood Disorders
- ☐ Head Injury
- ☐ Asthma
- ☐ Epilepsy
- ☐ Chemical Dependency
- ☐ Other Gastrointestinal disorders? ____________________
- ☐ **List all allergies:**___________________________________
  Latex?_____ ___________

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been diagnosed with any of the following conditions? (check all that apply)

___ Cancer _Heart Disease _Diabetes
___ Blood Clots High Blood Pressure Depression
___ Thyroid Problems Rheumatoid Arthritis/Conditions Stroke/TIA
___ Liver Problems ___Osteoporosis Seizure/Epilepsy

MEDICATIONS and Other

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*]
that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

____

____

____

Have you ever taken steroid medications? ☐ Yes ☐ No If yes, when, and for what condition________________________________
Are you currently taking blood thinners/anticoagulants? ☐ Yes ☐No If yes, how long and for what condition____________________________
History of smoking? Yes No