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. We also offer custom orthotics evaluation and fitting.

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

RealRehab
SPORTS + PHYSICAL THERAPY

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.
    - 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: _____

RealRehab
SPORTS + PHYSICAL THERAPY

Intake Information Form

How did you find out about our facility?

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

Patient Information

Last First M.

Address

City State Zip

Home Phone Cell Phone

Sex M ☐ F ☐

Work Phone Employer

Emergency Contact Name Phone

Date of Birth Age

Spouse's Name Work Phone

Responsible Party/Billing

Last First M.

Address

City State Zip

Home Phone Cell Phone

Sex M ☐ F ☐

Work Phone

Employer

Date of Birth Age

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

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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 or family emergency is excluded from this policy.

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

_____ _____

Patient (or Guardian) Signature Date

RealRehab
SPORTS + PHYSICAL THERAPY

INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET (Page 1)

Patient Name: _____ DOB: _____ Date of Eval: _____

SUBJECTIVE
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 <u>ALL</u> 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 (ie 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 [*<u>with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth</u>*)]
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

TURN OVER PLEASE

CURRENT COMPLAINTS

If you have pain, what is your pain level?

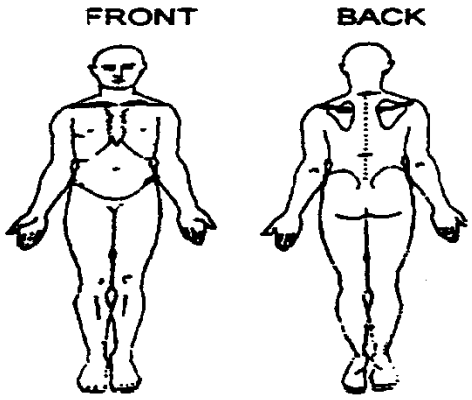
(0 = No Pain, 10 = Extreme Pain – Circle)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

CURRENTLY: 0 1 2 3 4 5 6 7 8 9 10

Mark the location of your pain with an "X":



Describe symptoms: □ Constant □ Come and Go □ Ache □ Deep □ Superficial □ Dull □ Sharp □ Shooting □ Burning □ Numb/Tingling
□ Other: _____

Symptom Pattern:

Does your pain seem to be WORSE at a certain time of day? □ Yes □ No If Yes, □ Morning □ Night □ Other:_____

Does your pain progress as the day goes along? □ Yes □ No If Yes, please explain: _____

Do you have difficulty sleeping? □ Yes □ No If Yes, please explain: _____

Do you wake due to pain? □ Yes □ No If Yes, # of times per night: _____

FUNCTIONAL ABILITIES AND RESTRICTIONS

What activities or duties are difficult to perform due to your condition? □ Squatting □ Sitting □ Standing □ Walking □ Lifting
□ Dressing/Grooming □ Driving □ Stairs □ Reaching □ Work Tasks □ Gripping/Pinching □ Kneeling □ Position Changes
□ Cooking □ Cleaning □ Vacuuming □ Laundry □ Yard Work □ Shopping
□ Exercise:_____ □Other: _____

Do you ever experience leakage of urine, even a small amount with activity? Yes No

Do you ever experience pain with intercourse (and/or for women - with tampon insertion)? Yes No

What makes your pain WORSE?_____

What makes your pain BETTER?_____

Occupation: _____ Presently Working: □ Yes □ No If Yes, □ Full Duty □ Limited Duty:

Restrictions: _____ # Days Off Work: _____ Job Duties: _____

Are you now, or have you ever been disabled? □ Yes □ No If Yes, when? _____Please explain: _____

Have you had any falls in the past 12 months? □ Yes □ No If Yes, how many times? _____ Injuries?_____

How would you classify your general health? □ Good □ Fair □ Poor

Please list hobbies and interests:_____

Describe your normal exercise and fitness activities, include details (i.e. Run 30 minutes, 3 times per week):

_____

List any event(s) with dates that you are preparing for:_____

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy?

1. _____
2. _____
3. _____

VITALS and PAR-Q

Heart Rate:_____ Blood Pressure:_____ PAR-Q Completed? Yes_____ NO_____

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date:_____

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DID YOU KNOW WE OFFER BIKE FITTINGS? VIDEO GAIT ANALYSIS? METABOLIC TESTING? ORTHOTIC DEVICES?