rehab advantage & sports medicine

Where the real advantage is in the results.

Rehab Advantage & Sports Medicine
Patient Information

PERSONAL DETAILS

Patient's Full Name:_____

DOB: _____

Mailing Address: _____

City_____ State_____ Zip_____

Home#:_____

Cell#: _____

Preferred Method of Contact? _____

Patient Email:_____

Height: _____ Weight: _____

Marital Status_____

Sex: _____ Male _____ Female___Other

How did you hear about us: _____

Who was your referring physician: _____

Primary Care Physician_____

Emergency Contact:_____

Relationship:_____Phone #_____

INSURANCE INFORMATION

Do you have primary insurance? _____Yes _____No

Name of insurance company: _____

Member ID: _____

Primary Policy Holder: _____

Policy Holder DOB: _____

Relationship to Primary Policy Holder: _____

Do you have the same address: _____

Do you have secondary Insurance? _____Yes _____ No Ins Comp Name: _____

Patient Employer:_____ Phone:_____

*Have you ever been a patient of Rehab Advantage & Sports Medicine?_____

Rehab Advantage & Sports Medicine, Inc.

Medical History

INJURY OVERVIEW

Why are you scheduling an appointment? (Location on body)

_____

Date of injury/symptoms:

_____

Is your visit related to a work injury or car accident? YES x NO
Any surgery related to your injury/condition? YES x NO
Are you currently receiving Home Health Services? YES xNO

Pain Information

PAIN SCALE: 0=NO PAIN —-- 10 WORSE PAIN

Pain at best: _____

Pain at worst: _____

Currently: _____

How often do you experience symptoms? Constant Intermittent
Does the pain vary based on what you are doing? YES (Varying) NO (Non-Varying)
Is the pain deep or superficial? Deep Superficial
Do you experience any numbness or tingling? Numbness Tingling
Do any of the following descriptions apply? Dull Sharp Shooting Aching Throbbing
Other Comments: _____

_____

Another Location? ☐ YES ☐ NO
Where are you experiencing pain? (Location on body): _____
Please indicate the intensity of the pain on a scale of 0 (no pain) to 10 (worst pain imaginable):
Pain at best: _____ Pain at worst: _____ Currently: _____
How often do you experience symptoms? ☐ Constant ☐ Intermittent
Does the pain vary based on what you are doing? ☐ YES (Varying) ☐ NO (Non-Varying)
Is the pain deep or superficial? ☐ Deep ☐ Superficial
Do you experience any numbness or tingling? ☐ Numbness ☐ Tingling
Do any of the following descriptions apply? ☐ Dull ☐ Sharp ☐ Shooting ☐ Aching ☐ Throbbing

Other Comments: _____

_____

Symptom Aggravation and Relief

What makes your symptoms feel worse? (Please circle all that apply)

Sitting Rising First few steps Standing Walking Stairs Bending

Squatting Kneeling Lifting Carrying When still When on the move

Prolonged Activity Rest Sleeping: Prone Sleeping: Back Sleeping: Right Side

Sleeping: Left Side

What makes your symptoms feel better? (Please circle all that apply)

Ice Heat Medication Sitting Standing Walking Stairs Bending

Squatting Kneeling Lifting Carrying When still When on the move

Prolonged Activity Rest Sleeping: Prone Sleeping: Back Sleeping: Left Side

Sleeping: Right Side

Day Pattern

Do your symptoms appear worse at a certain time of day? If yes, please explain when.

_____

_____

Do your symptoms increase upon awakening? ☐ YES ☐ NO

Do your symptoms progress throughout the day? ☐ YES ☐ NO

Do you have difficulty falling asleep due to your symptoms? ☐ YES ☐ NO

Do you wake throughout the night due to your symptoms? If yes, please mention roughly how many times.

_____

_____

LEVEL OF FUNCTION

How have your abilities changed due to the injury?

Prior Level of Function:

_____

Current Level of Function:

_____

MEDICAL AND SOCIETAL HISTORY

What is your occupation? _____

Are you presently working? ☐Full Time ☐Part Time ☐Limited Duty ☐NO

Have you been off work due to your symptoms? If yes, tell us how many days.

_____

What are your job duties?

_____

What is your living situation? ☐House ☐Apartment ☐Other: _____

Does your home have stairs? ☐YES ☐NO

Do you live with others? ☐Alone ☐Roommates ☐Family ☐Others: _____

What are your responsibilities at home?_____

_____

Do you have symptoms while taking care of responsibilities at home? Yes _____No_____

What are your leisure activities outside of work and home responsibilities?

_____

Do you have symptoms with any of your leisure activities? ☐YES ☐NO

How many days per week do you exercise?

_____

What do you do for exercise?

_____

Medications

Please write below or attached medicine list. Provide **Medication Name**, **Dosage, Frequency**.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PRECAUTIONS

Do any of the conditions below apply to you? Circle all that apply.

High Blood Pressure	History of Heart Problems	High Cholesterol	Pacemaker	Asthma, COPD, Emphysema or Other	Bleeding or Clotting Disorder	Anemia	Diabetes
Dizziness or Feeling off Balanced	Vision Problems	Concussion	History of Falls or Falling	Anxiety, Depression or Panic Attacks	Arthritis or Joint Pain	Artificial joints	Kidney Disease
Hepatitis or HIV	Fractures	Thyroid Problem	Seizures	Chronic or Migraine Headaches	TMJ Disorders	Chills or Fever Sweats	Swelling of Extremities
Sleep Disorder	Long COVID	Fibromyalgia	Chronic Fatigue Syndrome	Lyme Disease	Cancer	Are you Pregnant?	Bladder or Bowel Incontinence
Unexplained Weight Loss	Other:						

AUTHORIZATION: Please Review, Initial, Sign, and Date

Advance Beneficiary Form - Medicare Cap - Communications - HIPAA

The Medicare cap for physical therapy services is $2,410. This means that beneficiaries can receive up to $2,410 in covered physical therapy services per calendar year.

Additional Information:

- The cap is a threshold, not a limit. If a beneficiary reaches the cap, they can still receive physical therapy services if they are medically necessary.
- Services that exceed the cap may be subject to a targeted medical review.
- The beneficiary's provider will typically notify them if they are approaching the cap.

Medicare Cap Initial: _____

Additionally, Rehab and Sports Medicine may provide services and/or objects (i.e. balls, putty, pulleys, etc.) that are not covered by Medicare. Please be advised that this serves as our **Advance Beneficiary Notice of Non-coverage** and you will be responsible for these charges. We will make every effort to inform you of these charges before they are incurred.

Advance Beneficiary Notice Initial: _____

Keeping your information confidential is of the utmost importance to us. We follow all HIPAA guidelines to keep your Personal Health Information (PHI) confidential with paper and Electronic Medical Records (EMR). If you would like a copy of these guidelines, please see the front desk for a copy. In addition, this policy is posted in our lobby.

HIPAA Initial: _____

Communication from us will be managed through fax, email, phone, and text messaging. All forms of communication are secure and confidential. This includes all electronic communications for health care operations in which it may be necessary to disclose protected health information to another entity, and this serves as your authorization.

Communication Initial: _____

As a courtesy to our patients our office will bill your insurance carrier(s) for the services rendered by Rehab Advantage & Sports Medicine, INC. Not all therapy services are covered under certain insurances, Medicare, or Medicaid. In some cases, the amount of eligibility and coverage can only be determined after the insurance carrier processes your claim. To minimize any out of pocket costs that may occur, we ask you to contact your employer/insurance carrier to expedite authorization of payment.

Payment Initial: _____

Authorization To Release Information:

I hereby grant Rehab Advantage & Sports Medicine to release pertinent medical and/or billing records to my insurance company, attorney, or physician, which is designated by me.

Assignment of Insurance Benefits:

I hereby authorize Rehab Advantage & Sports Medicine direct payment of medical benefits, otherwise payable to me but not to exceed the charges stated on claim.

I understand

I AM FINANCIALLY RESPONSIBLE TO THE PROVIDER FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

Authorization of Treatment:

I hereby authorize Rehab Advantage & Sports Medicine to provide the appropriate level of therapy care deemed necessary by the treating therapist and/ or therapy assistant. A copy of this authorization shall be valid as the original…….

Our office files insurance as a courtesy to the patient. It is your responsibility to follow up if they do not pay in a timely manner. We will be glad to provide you with paperwork to re-file if needed.** Please note that you are responsible for your copay *at time of visit*. Your balance is determined by your insurance company (as noted on your EOB as "patient responsibility"). If you have not met your deductible, our office will work with you on a payment schedule (please notify our staff). The undersigned is responsible for all costs incurred including, but not limited to, deductibles and co-pays, either through the insurance or out of pocket expenses. If our office does not receive payment in full within 60 days of rendered services, the patient, parent or legal guardian will be liable for payment. If litigation or collections is necessary to collect unpaid debts, the undersigned agrees to pay for all costs incurred.**

Insurance Release and Benefit Assignment Initial: _____

Signature of Patient or Legal Guardian for all Authorization listed above:

Signature: _____

Date: _____