REHAB Pilates
PHYSICAL THERAPY & PILATES

Patient Name: _____
Last Name First Name Initial

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-Mail_____

Date of Birth: _____ Age: _____ Male _____ Female_____

How did you hear about RehabPilates?_____

****

Employer: _____ Occupation: _____

Employer Address: _____

****

Please fill this section out if you plan on submitting a reimbursement form to your insurance company.

Name of Insurance: _____

ID#/ Policy #/ Claim #: _____ Date of Injury/Illness: _____

Social Security #: _____

Primary Care Physician: _____ Phone: _____

****

1st Emergency Contact: _____ Relationship: _____

Phone : _____ Cell Phone:_____

2nd Emergency Contact: _____ Relationship: _____

Phone : _____ Cell Phone:_____

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian Signature (If a minor) Date

MEDICAL HISTORY

Have you ever had:	YES	NO	PLEASE EXPLAIN
Head Injury/Concussion			
Seizure/ Epilepsy			
Diabetes			
High Blood Pressure			
Heart Conditions or Surgery			
Hospitalization			
Surgery			
Arthritis			
Osteoporosis/Osteopenia			
MRI or CT Scan			
Joint pain			
Fracture			
Stroke or TIA			
Asthma or shortness of breath			
Allergies			
Cancer			
Wound/ Skin infection			
Bowel/ Bladder incontinence			
Pacemaker Metal Implant			
Physical Therapy in the last 60 days			
Please list Medications :			
Please list any other Medical Conditions that you may feel we should know about:			

I will advise the therapist if there is any change in my response to any of the above.

_____ _____

Patient's Signature Date

_____ _____

Parent or Legal Guardian Signature (If a minor) Date

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1. CONSENT OF DISCLOSURE I hereby give consent to RehabPilates Physical Therapy & Pilates, Inc. and all health care providers furnishing care within RehabPilates Physical Therapy & Pilates, Inc. to use and disclose my protected health information for the purposes of treatment, payment and health care options.

You may cancel this consent at any time. Your cancellation must be in writing signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail; however it will only be effective when we actually receive it.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Privacy Policy. This policy is available at our front desk.

Print name _____ Signature _____

Date _____

2. INFORMED CONSENT I hereby consent to physical therapy, Pilates instruction or massage under the general and specific instructions from the treating Physical Therapist/ instructor or massage therapist at RehabPilates Physical Therapy & Pilates, Inc.

Initials _____

3. RELEASE FROM LIABILITY I fully agree for myself and heirs, to hereby fully and forever discharge and release RehabPilates Physical Therapy & Pilates, Inc. from any and all liability, all claims and demands, actions and causes of action whatsoever arising out of any damages, costs, loss of services, expenses and all claims whatsoever, whether caused by their negligence or for any other reason, on account of, or in any way resulting from personal injuries, conscious suffering, death or property damages to myself or to any other person or property, in any way connected with my preparation for or participation in the activities. I agree not to sue RehabPilates Physical Therapy & Pilates, Inc., its owners, or employees. In the event of any dispute or controversy arising with respect to this release, said dispute will be resolved in binding arbitration proceedings conducted by the American Arbitration Association.

Initials _____

4. FINANCIAL AGREEMENT I herby individually obligate myself to pay the accounts for services rendered by RehabPilates Physical Therapy & Pilates, Inc. in accordance with the regular rates and terms of this provider.

Initials _____

5. I understand that it is my responsibility to inform my therapist/instructor if I experience pain or increased pain anywhere in my body.

Initials _____

_____ _____
Patient's Signature Date

_____ _____
Parent or Legal Guardian Signature (If a minor) Date

Tell us about your problem so we can help you:

1. Describe your symptoms: What is your pain level?

1 2 3 4 5 6 7 8 9 10
least painful to most painful

2. Where do you feel the pain?

_____

3. When did your symptoms begin? How?

_____

_____

4. What treatments have you had?

_____

_____

5. What activities cause/ increase the pain?

_____

_____

6. What helps/ decrease the pain?

_____

_____

7. What are your limitations or things you are unable to do because of your symptoms?

_____

_____

8. What are your goals for Pilates/physical therapy at RehabPilates?

_____

_____

No Show / Cancellation Policy

Please Read Carefully

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notification allows us to fulfill other patient's scheduling needs and keeps the clinic operating at its most efficient level. Due to our policy of providing one-on-one care, missed appointments are a significant inconvenience to your physical therapy treatment, other patients and the staff of the clinic.

_____ (initial) A 24-hour advance notice is required to change or cancel an appointment. You acknowledge your responsibility to pay a $30.00 office visit charge out-of-pocket for not attending a scheduled appointment or not providing a 24-hour advance notice to cancel an appointment. This fee cannot be billed to insurance and must be paid by you on or before your next scheduled appointment.

We reserve your one-hour appointment just for you. The 24-hour notice helps us to place another patient in the appointed time.

After missing two appointments without notice, you will be placed on a same day schedule policy for your treatments, which would prevent you from scheduling your appointments in advance.

We greatly appreciate you providing our office and its patients with this courtesy.

Your signature indicates you understand and agree to the terms of this policy.

_____ _____

Patient's Signature Date

_____ _____

Parent or Legal Guardian Signature (If a minor) Date

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Under California law, you may receive direct physical therapy treatment services for 12 visits or 45 days, whichever comes first. You may continue physical therapy services after this time by providing a written referral from a licensed physician or appropriate practitioner.