Results
Rehabilitation, Inc.

General Info + Health History

How did you hear about us? (Please Check)

1) Doctor Referral**:** _____ **2)** Family/Friends: _____ **3)** Internet (Website/Social Media): _____

4) Print Media (Newspaper, Magazine, Valuebook): _____

Print Name:_____ Date of Birth: _____ SSN:_____

Address:_____ City: _____ State: _____ Zip:_____

Home Phone: _____Cell Phone: _____ E-Mail: _____

Emergency Contact Name:_____ Contact#: _____ Relationship: _____

Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____ City: _____ State: _____ Zip:_____

Primary Insurance: _____Secondary Insurance: _____

How were you referred: _____ Physician: _____ Last Visit? _____

When did your pain or problem start? _____

What kind of pain do you have? _____What have you done for it so far? _____

Primary Position During the Day? Standing _____ Sitting _____ Moving _____Other: _____

Rate your pain: (0= no pain, 10= worst pain imaginable) Circle one: 0 1 2 3 4 5 6 7 8 9 10

Medications:_____

What Activities Cause Pain:

Sleeping _____ Turning in Bed ____Sitting Up _____Sitting _____ Standing Up _____
Walking _____ General Balance _____ Recent Falls _____ Climbing Stairs _____
Descending Stairs ____ Picking Something Off The Ground __ Lifting Grocery Bag __
Lifting Arms Up Over Your Head _____ Dressing _____ Brushing/Styling Hair _____
Washing/Grooming _____Other_____
What Is The Most Difficult Thing For You To Do? _____
_____

Current Occupation:_____Hours Worked Per Day: _____Per Week: _____
Previous Occupations: _____How Are You Commuting: Drive Yourself ___Bus ___Train _Walk __

Results
Rehabilitation, Inc.

Any major physical traumas in your life? (Vehicle accidents, falls, surgeries, etc.) Yes_____No_____ If yes, explain:_____

_____

_____

CURRENT PAIN SYMPTOMS

LOCATION	LEFT	RIGHT	INTERMITTENT (I) OR CONSTANT (C)	WHAT MAKES IT WORSE?	WHAT MAKES IT BETTER
Neck					
Upper back					
Shoulder(s)					
Low back					
Pelvis					
Hip(s)					
Knee(s)					
Ankle(s)/foot					
Elbow(s)					
Wrist/Hand(s)					

ANY MEDICAL HISTORY OF

		YES	NO			YES	NO
1	High Blood Pressure			10	Arthritis		
2	Cholesterol			11	Metal Implants		
3	Dizziness			12	Stroke of TIA		
4	Headaches			13	Hernia		
5	Asthma			14	Cancer		
6	Cardiac Problems			15	Endometriosis		
7	Pacemaker			16	Constipation		
8	Diabetes			17	Digestive Problems/Ulcers		
9	Circulatory Disorders			18	Depression		

Results
Rehabilitation, Inc.

RESULTS REHABILITATION INC. (DBA Results Physical Therapy)
ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Results Rehabilitation Inc. (Results PT) notice of patient information practices. I understand that (Results PT) may disclose personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services or others listed on the notice. I understand that I have the right to restrict how my Protected Health Information (PHI) is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my PHI as noted in the Results PT notice of patient information practices. I understand that I retain the right to revoke this consent by notifying Results PT in writing at any time.

Print Full Name: _____

Patient or Guardian Signature: _____

RESULTS REHABILITATION INC. (DBA Results Physical Therapy)
Cancellation Policy

The following is our policy regarding cancellations and "no shows." We take this subject seriously because it can make the difference between whether you succeed in your treatment goals or not. Showing up for your scheduled sessions is one of your most important jobs.

We require a 24 hour notice in the event of a cancellation.

1. This notice can be telephonic at 619-437-6450 or through e-mail at results@resultsrehab.com
2. There is a $50.00 charge for a cancellation without a 24 hour notice or a "no-show." This charge cannot be billed to your insurance making it your direct responsibility to pay.
3. Your missed appointment will be re-scheduled as soon as your and our schedules permit.
4. Your therapists are contracted clinicians and do not get reimbursed for your sudden cancellation or "no-Show." Please be courteous to all of those involved and cancel with greater than 24 hour notice so the appropriate schedule adjustments can be made and allow us to serve other patients in need of our services.
5. We reserve the right to discontinue your treatments after a series of missed or canceled appointments.

Signature : _____ Date : _____

Results
Rehabilitation, Inc.

BILLING INSURANCE:

Please **Check + Initial** the medical insurance plan that applies to you:

☐ **Workers compensation insurance:** We will request authorization from your workers compensation insurance carrier on your behalf. We will not be responsible for costs incurred by the authorized treatment. You agree that Results Physical Therapy may release medical records to the insurance company for billing purposes. We are also obligated to inform the insurance earner and or the employee if appointments are not kept or compliance with your program is not met.

☐ **Medicare Insurance:** We accept Medicare assignment and will bill the Medicare assigned insurance company for you. By law, you are responsible for 20% copayment as well as any deductible cost. You will be billed for any copayments after we received Medicare explanation of benefits. Balances that remain after 45 days for billing will be subject to interest up to maximum of 1.5 percent but not inexcess of the maximum interest rate allowed by law. There is a $25 fee for returned checks.

☐ **Other Insurance plan:** As a courtesy to you, our office will contact your insurance company requesting information regarding you deductible, copayment and terms of coverage for services. We will inform you of their quote to us but it's not a guarantee of their corporation of payment. Your Insurance policy is a contract between you and your insurance carrier. Results Physical Therapy is not part of this contract. Results Physical Therapy is or is not a participating provider.

Your deductible and copayment are due at the time services. Your copayment for the treatment is depending on your insurance policy and/or contractual rate reimbursement by your insurance. There is a $25 fee for returned checks. Most policies allow six weeks from the date of treatment for payment if your deductible and any percentage insurance does not cover. Please be aware that some, and perhaps all, of the services provided may be non-covered services and are not considered reasonable and necessary under your medical insurance. We reserve the right to charge interest on the outstanding concept of 1.5% per month but not in excess of the maximum interest allowed by law. If it becomes necessary for the account to refer to an attorney for collection or collections agency, you're liable for reasonable attorneys fees and collection expenses.

Please sign below, indicating that you have read the above and to agree to the terms set forth. By signing below, you further agree to final and binding arbitration for any and all claims, disputes or controversies arising between you and Results Physical Therapy, whether contractual, statutory or common law. Additionally you agree to waive your rights to a jury trial and to utilize the services of, and to arbitrate under the rules promulgated by the American Arbitration Association.

Signature : _____ Date : _____

Results
Rehabilitation, Inc.

MEDICARE CAP ALERT

As of January 1, 2018 Medicare increased Outpatient physical therapy coverage to $2010 per beneficiary for 2018. This amount of money per year is shared with speech therapy if you have treatments used by speech therapist.

You will be limited for the amount of physical therapy treatments you are allowed to receive. Results physical therapy is a privately owned outpatient physical therapy clinic and falls under these cap restrictions. Generally speaking you are limited to approximate 10 to 14 treatment sessions for physical therapy to reach the cap. We will inform you when it is getting close to reaching the that amount of treatment or dollar amount.

EXCEPTIONS:

1. When the cap is reached, it is then determined by the therapist(s) and your own current and remaining physical and functional impairment assessment, whether you are a candidate to be seen and treated beyond the regular limitations set by Medicare. This also requires strict documentation by your therapist providing functional gains in activities of daily living. The treatment plan has to be signed and dated by the referring physician.
2. You are also allowed to continue physical therapy beyond the yearly cap to improve your condition and work towards physical conditioning beyond the allowed Medicare guidelines when and if you agree to sign an Advance Beneficiary Note 'ABN', telling Medicare that you are not expecting to be paid by Medicare anymore and that you will utilize:

   a) a **secondary insurance** for payment.

      (This is not to be mistaken with a **supplemental** insurance which only pays 20% of the allowed Medicare percentage coverage and only pays when Medicare pays.)

   b) or you're willing to **pay privately** without utilizing any insurance coverage. The treatment plan has to be signed and dated by the referring physician.

I understand the above stated Medicare policies for Physical Therapy.

Signature: _____

Results Rehabilitation, Inc., 1224 Tenth Street Suite 204, Coronado, Ca, 92118

Phone: 619-437-6450, fax: 619-259-5197, www.resultsrehab.com

Results
Rehabilitation, Inc.

Waiver and Release of Liability

I'm agreeing to receive care provided by RESULTS REHABILITATION INC ("Results Rehabilitation Inc") and to use the on and off-site facilities provided by RESULTS REHABILITAION INC located on site at 1224 10th St, Ste. 204 Coronado, CA 92118 and offsite including various promotional events and educational workshops, I agree as follows:

I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Results Rehabilitation Inc and the physical therapy activities and equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of Results Rehabilitation Inc, the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Results Rehabilitation Inc, or by any other person.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Results Rehabilitation Inc and their representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Results Rehabilitation Inc.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE RESULTS REHABILITATION INC FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Name (print) _____ Date of birth _____

Signature _____ Date _____