Results
Physical Therapy

Patient 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, Value book):_____ 5) Email:_____ 6) Other:_____

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

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

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

Occupation: _____ Employer: _____ Work Phone: _____

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

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

Primary Insurance: _____Secondary Insurance: _____

Why are you seeking care from a Physical Therapist? _____

When did your pain or symptoms start? _____

What kind of symptoms do you have?* **Sharp pain___ Dull ache___Numbness/tingling___Other:** _____

What have you done for it so far?* _____Pain scale: 1 2 3 4 5 6 7 8 9 10

Primary Position During the Day**?*** **Standing ___ Sitting _____ Moving ____ Other:** _____

Do you take any medications for current symptoms and/or other medical condition? * **Yes____ No____**

If yes, please list them: _____

Any major physical traumas in your life? Vehicle Accident _____ Recent Falls_____ Surgeries_____

If yes, please explain:_____

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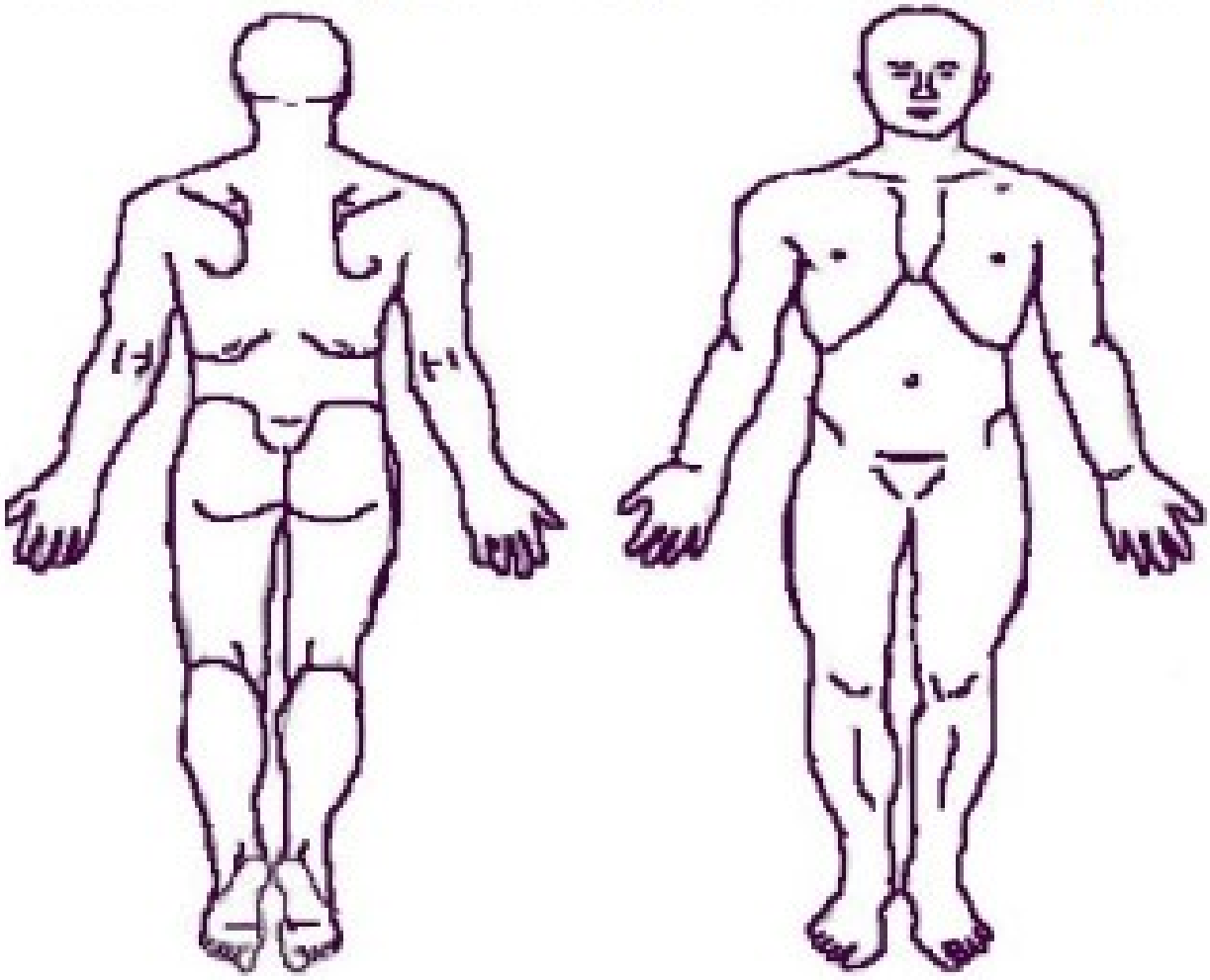
Indicate where you have pain or other symptoms:*



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CURRENT PAIN SYMPTOMS (Please check)*

LOCATION	LEFT	RIGHT	INTERMITTENT (I) OR CONSTANT (C) (Please Circle)	WHAT MAKES IT WORSE?	WHAT MAKES IT BETTER
Neck			I C		
Shoulder			I C		
Elbow			I C		
Wrist/Hand			I C		
Upper Back			I C		
Mid/Low Back			I C		
Pelvis			I C		
Hip			I C		
Knee			I C		
Ankle/foot			I C		
Others:			I C		

MEDICAL HISTORY *

	YES	NO		YES	NO
High Blood Pressure			**Arthritis**		
Cholesterol			**Metal Implant(s)**		
Dizziness			**Stroke or TIA**		
Headaches			**Hernia**		
Asthma			**Cancer**		
Cardiac Problems			**Endometriosis**		
Pacemaker			**Depression**		
Diabetes			**Digestive Problems/Ulcers**		
Circulatory Disorders			**Other: _____** _____		

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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 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 therapist(s) 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.
4. We reserve the right to discontinue your treatments after a series of missed or canceled appointments.

RESULTS REHABILITATION INC. (DBA Results Physical Therapy)
ACKNOWLEDGEMENT 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.
I have read and fully understand Results Rehabilitation Inc. (Results PT) notice of patient information practices.

Print Name : _____ Signature : _____

Date : _____

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MEDICARE HOME HEALTH PT CONFIRMATION: Prior to starting outpatient physical therapy at Results Rehabilitation Inc., have you received any Home Health Physical Therapy services? **Yes_ No_** If yes, Home Health Physical Therapy services were officially discharged: **Yes_ (DC date:_____) No__Not Applicable__**

MEDICARE CAP ALERT

As of January 1, 2026, Medicare increased Outpatient physical therapy coverage to **$2,480** per beneficiary for 2026. This amount of money per year is shared with speech therapy if you have treatments used by a speech therapist.

Results Physical Therapy is a privately owned outpatient physical therapy clinic and falls under these cap restrictions. Generally speaking, you are limited to **approximately 12 to 15 treatment sessions** for physical therapy to reach the cap. We will inform you when it is getting close to reaching that amount of treatment or dollar amount.

We 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.

EXCEPTIONS:

1. When the cap of $2,480 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.

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) **Secondary Insurance**

    (This is not to be mistaken with Supplemental Insurance which only pays 20% of the allowed Medicare percentage coverage and only pays when Medicare pays.)

    b) **Private Pay**

I understand the above stated Medicare policies for Physical Therapy.

Signature: _____

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Informed Consent and Liability Waiver

I consent to the services provided at Results Rehabilitation Inc. These services include but are not limited to; rehabilitative procedures, manual joint mobilizations, massage, therapeutic exercises, and physical agents (ultrasound, low-level laser, electrical stimulation, traction, ice, heat therapy, etc.) to facilitate healing and aid the patient in recovery. I am voluntarily choosing to participate in and receive physical therapy. I will be expected to fully cooperate during the evaluation and treatment program in order to maximize results. I should not experience an increase in pain or discomfort beyond its current level during the evaluation and treatment program. If I feel increased pain, discomfort or feel apprehensive, it is my responsibility to ask the therapist to stop the procedure immediately. I will never be forced to perform any procedure that I do not wish to perform. There are certain inherent risks for physical therapy treatments because I will be asked to exert effort and perform activities with increased levels of difficulty. My therapist will take every precaution to ensure that I am protected from any potential hazardous situation. Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and comply with the plan of care as it is established.

I hereby give my consent to participate in physical therapy at Results Rehabilitation Inc. that includes my permission to be evaluated by a licensed physical therapist and receive treatment by licensed PT professionals. I, the undersigned, hereby release Results Rehabilitation Inc. and it's employees, students, and volunteers from all liability arising out of or in connection with the above described activity or all liabilities associated with any and all claims related to such activity that may be filed on behalf of or for the below named patient. For purposes of this agreement, liability means all claims, demands, losses, causes of action, suits, or judgements of any and every kind that occurs during the above-described activity and that results from any cause other than the negligence of Results Rehabilitation Inc.

Print Name: _____ Signature: _____

Date: _____

*If under 18 years of age:

Parent/Legal guardian Signature: _____

*** Upon request we are happy to provide you with a copy of the American Physical Therapy Association Guide of professional conduct.