RYBACKI
PHYSICAL THERAPY

PATIENT INFORMATION

Last Name | First Name | MI | Male | Female

Street Address | Apt

City | State | Zip

Home Phone # | Mobile # | Date of Birth

Appointment reminders (check all that apply): Call Text Email

Marital Status: S M D W

Email

Employer

Employers Address

Work Phone

Emergency Contact Name | Relationship

Contact Phone # | Contact Mobile #

Referred to our office by | Phone #

Primary Care Physician | Phone #

INSURANCE INFORMATION

Insurance card required to file Insurance

Primary Insurance | Policy Holder's Name

Policy Holder's Date of Birth | Relationship to Insured

Policy Holder's Employer

Insurance Address

Member ID # | Group/Plan #

Signature of Patient/ Guarantor/ Guardian | Date

MEDICAL QUESTIONNAIRE

RYBACKI PHYSICAL THERAPY

Patient Name

Check all the symptoms that apply

☐ Aching ☐ Constant ☐ Sharp/Stabbing ☐ Intermittent
☐ Numbness ☐ Burning ☐ Tingling ☐ Other

Circle your worst pain in the last couple of days:

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Circle your best pain in the last couple of days:

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Approx. when did your pain start? ____/____/____

If ongoing, the most recent date symptoms worsened: ____/____/___

List three things that make your pain worse (ie: sitting, standing, bending...): _____

_____

_____

In the past month, is the pain getting worse, better or staying the same? _____

Are any of your usual day to day activities affected? Yes No If Yes, please list:

_____

List all past surgeries with dates:

_____

Have you had any concussions? Yes No

Have you fallen on your tailbone? Yes No

Have you had any traumatic injuries/accidents? Yes No

Circle all medical conditions you were told you have:

Arthritis	Anxiety
Asthma	Bleeding Problem
Breathing Difficulty	COPD
Cancer	Depression
Diabetes	Heart Problems
Hearing Problems	High Blood Pressure
High Cholesterol	IBS (Digestive)
Migraines	Osteoporosis
Seizures	Thyroid Problem

Other: _____

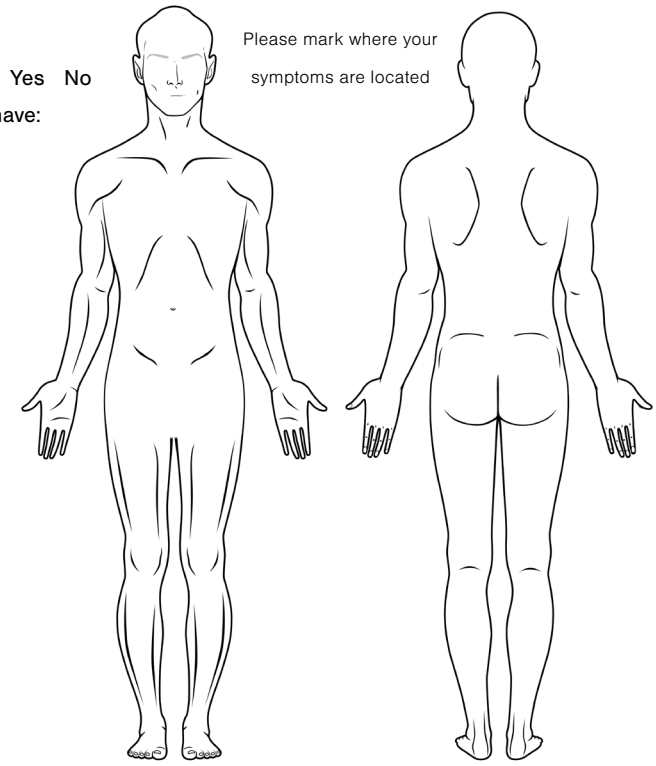
Please provide a list of all of your current medications (photocopies are acceptable)

_____

_____

_____

Please mark where your symptoms are located



AUTHORIZATION FORM

RYBACKI PHYSICAL THERAPY

Please initial all applicable areas and sign below.

AUTHORIZATION FOR TREATMENT: I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize Rybacki Physical Therapy, LLC to provide such treatment.

Initials

PAYMENT AUTHORIZATION: I request that payment be made on my behalf to Rybacki Physical Therapy, LLC for services furnished to me by Rybacki Physical Therapy, LLC I authorize Rybacki Physical Therapy, LLC to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payer all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR PHYSICAL OR OCCUPATIONAL THERAPY SERVICES RENDERED.

Initials

HIPAA PRIVACY POLICY: I have been provided a copy of the HIPAA Privacy Policy at www.rybacki.com/hipaa for review and know that if I would like a copy of it to keep, I can request one.

Initials

CANCEL/NO SHOW POLICY: Twenty four hours notice must be given for any cancellation or re-scheduling of appointments. Failure to give notice will result in a $45.00 cancellation or no show fee, which will be payable at your next scheduled appointment. Payment must be made before continuing physical therapy.

Initials

RECORD RELEASE: I am aware that Rybacki Physical Therapy, LLC may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care.

Initials

PAYMENT AUTHORIZATION – PROMPT PAY: If you do not want your services billed to an insurance company, charges must be paid in full at the time of service in order to receive the discount. The amount charged is determined by the length of treatment as follows: $150.00 evaluation and $30.00 per 15 minutes. If a supply or pre-fabricated orthotic is issued, there will be an additional charge. I do not want my services billed to an insurance company, and will not do so myself.

Initials

MEDICARE PATIENTS ONLY: Are you currently, or in the last 30 days received any type of Home Health Services, physical/speech/occupational therapy from a home health care agency, transitional care facility, or nursing home?

_____Yes _____No (If yes, we cannot treat you today unless you have been discharged as Medicare will not pay for our services while you receive any of the above) You are responsible to make us aware of any previous treatment you may have had at an outpatient physical therapy facility in the past 12 months.

Initials

SELF REFERRAL: I understand that if I have not been referred by a physician. I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a licensed physician.

Initials

As part of working with my insurance carrier, I recognize that Rybacki Physical Therapy, LLC may be provided with information about my insurance coverage, and that on occasion Rybacki Physical Therapy, LLC may share some of this information with me. However, I understand and acknowledge that Rybacki Physical Therapy, LLC is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan documents and/or working with my insurance carrier to determine the scope and details of any available insurance coverage. By signing below, I agree that I am responsible for the bill for any services rendered for myself or the patient for whom I am signing.

Signature of Patient/Guarantor/Guardian

Date