Sarah Dible, PT. Location: ***Flourish a SPACE for Dimensional Healing***
300 East 24th Street. Vancouver, WA 98663
P: 360-798-7645 F: 360-553-4165 - rejuvenancetherapy@gmail.com_REJUVENANCE.COM

PATIENT REGISTRATION:

Name: First, Middle, Last Name:_____

Nickname:_____ e-mail:_____

DOB:____/____/____

Your Address:_____

City:_____State:_____Postal Code:_____

Phone:_____

Insurance:_____

Insurance Address:_____

_____

Guarantor name:_____DOB of Guarantor:____/_____/_____

Employer:_____

Ins Phone:_____

Group#:_____

Subscriber ID:_____

# of Visits Allowed:_____

Is **Sarah Dible or Rejuvenance Therapy a "Preferred Provider" with your insurance at address 204 E 25th St.**: Yes / No ***Look up or call insurance and confirm this***. If not do you have **out of network** benefits:_____

Out of network Details:_____

Policy dates:__/____/_____ to _____/____/_____

Co pay: $_____ or _____%, Deductible: _____, Met?_____

Is Authorization required?:_____

Additional info:_____

What are you coming to PT for:_____

What caused it: MVA:_____, Fall:_____, Re-injury:_____

Your Doctor's Name:_____

Doctors address/Phone/Fax #:_____

_____

IT IS YOUR RESPONSIBILITY TO CHECK YOUR BENEFITS AND INSURANCE COVERAGE. YOU WILL BE RESPONSIBLE FOR PAYMENT IF YOUR INSURANCE IS NOT COVERING YOUR VISITS!

Signature:_____Date:_____

Patient Printed Name:_____

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SARAH DIBLE MSPT/REJUVENANCE THERAPY PATIENT CONSENT/WAIVER:

HEALTH INFORMATION: Your personal health information, which includes your entire medical history and information about services provided to you, is protected by law. This health record serves as a basis for planning your treatment, communication between your health care professionals, legal documentation, verification of treatment for third party payers, and a tool to improve your care based on outcomes. Although this record is the physical property of the health care provider, this information also belongs to you and you have rights regarding the privacy of your records. A detailed explanation of these rights is available at the front desk and a copy is available to you upon request. In order to provide the best care possible, we may need to discuss your case with other health care professionals and health care facilities. By signing below, I authorize Rejuvenance Therapy or Sarah Dible, MSPT to release my medical records to my physician and my other health care professionals. I also authorize Rejuvenance Therapy to request pertinent medical records from these professionals (including copies of related imaging.)Please list pertinent health professionals and their contact information:

_____

_____

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. By signing below, I agree that I have been informed about this privacy practice and my protected health information and how to obtain a personal copy of this form and privacy policy.

CONSENT TO TREAT: You are an important partner in your health care decisions and play an active role in the outcome of your medical care. Thus, it is important that you are informed about benefits, risks, evaluations, and decisions about your care while being seen at this office. If you have questions, symptoms, or problems related to your care it is your responsibility to notify your physical therapist and consult with your primary care provider as necessary.

CREDIT AND PAYMENT POLICIES: Our goal is to provide you with the highest quality care at a reasonable/reduced cost compared with many clinics. For patients utilizing insurance, co- payments and estimated co-insurance for the day's treatment will be collected when you check- in for your appointment. Your insurance contract is between you and your carrier. As a courtesy to you, we will submit claims to most carriers. However, it is your responsibility to pay the required co-payments or uninsured amounts at the time of service. Self-pay patients will be expected to pay for services in full at the conclusion of their appointment (a "Time of Service" discount is offered to these patients not billing insurance.)

PATIENT MISSED APPOINTMENT POLICY: We are committed to fully assist you with your rehabilitation needs and thus, you are expected to attend all of your appointments. We are reserving this time specifically for you. If you need to cancel or reschedule an appointment, please do so 24-hours prior to your appointment time. A $25 fee will be charged for sessions missed without such prior notification. This fee will be due prior to your next treatment (insurance is not responsible for this fee.) All cancellations and no shows are documented in your medical record. We understand there are occasional emergency situations and we appreciate your consideration of our time. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, you agree to this policy.
By signing below, I agree to be treated by Rejuvenance Therapy - Physical Therapy, knowing there may be potential risks along with benefits, and I am willing to be an active participant in my own care.

Signature:_____ Date:_____

Patient Printed Name:_____

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Health History Questionnaire:

Briefly describe the problem that brings you here today: _____

_____

_____

Date the above problem started:_____

Other treatments you have had for this problem:_____

_____

Please list any known allergies and their symptoms:

_____

_____

_____

Please list any medications or supplements that you are currently taking:

_____

_____

_____

General Health History: check all that apply

[ ] Arthritis	[ ] Stroke	[ ] Fibromyalgia
[ ] Cancer: [ ] In remission	[ ] Stomach Disorders	[ ] Headaches
[ ]Diabetes	[ ] Anxiety	[ ] Hearing Problems
[ ]Heart Disease	[ ] Back Injury	[ ] Numbness or Tingling
[ ] High Blood Pressure	[ ] Pacemaker	[ ] Arthritis RA/OA
[ ] Lung Disease	[ ] Visual Problems	[ ] Allergies/Hay Fever
[ ] Allergies	[ ] Kidney Disease	[ ] Sleep Disorders
[ ] Asthma	[ ] Skin Disorder	[ ] Head Injury
[ ] Epilepsy	[ ] Osteoporosis	[ ] Fracture
[ ] Chronic Pain	[ ] Fatigue	[ ] Hernia

Current pain level:

0 1 2 3 4 5 6 7 8 9 10

No Pain Too much pain

Is your pain [ ] Constant [ ] Increasing Decreasing [ ] Staying the same [ ] Occasional

What makes your pain worse?_____

Prior to your injury or problem, what activities could you do that you are unable to do now?____

_____

Patient Printed Name:_____

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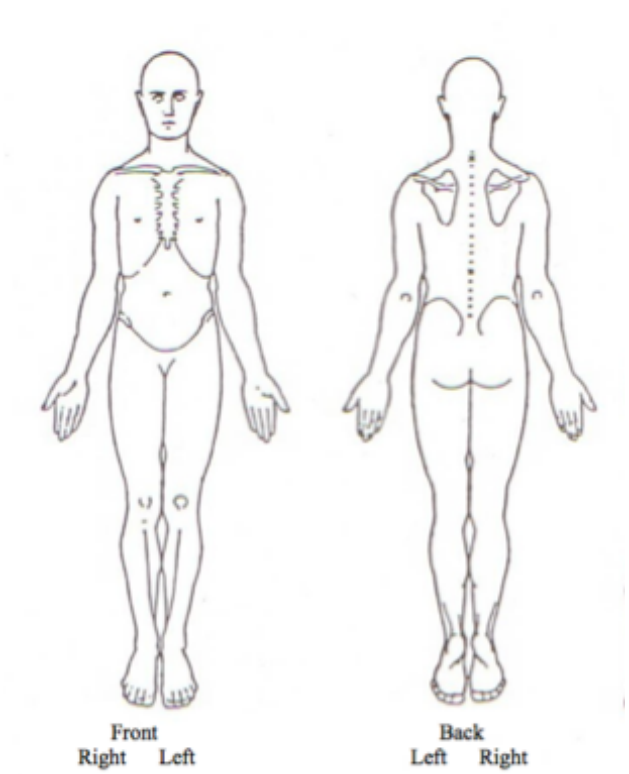
Your usual activity level: [ ] Low [ ] Medium [ ] High

Do you smoke?	[ ]Yes	[ ]No
Do you exercise regularly?	[ ]Yes	[ ]No
Do you use drugs?	[ ]Yes	[ ]No



Please use this diagram to indicate your symptoms:
OOOOOO = Numbness and tingling
XXXXXXX = Pain

What are your personal goals for physical therapy? Check all that apply:

[ ]Improve home activities
[ ]Improve leisure/sport activities
[ ]Improve self care activities
[ ]Decrease allergic response
[ ]Improve mobility/walking activities
[ ]Decrease or eliminate pain/discomfort
[ ]Return to work

Other goals:_____

Please include any other information you feel will helpful for your care:_____

_____

_____

Patient Printed Name:_____