RUBINO
physical therapy + sports wellness

Rubino Physical Therapy, Inc.

Patient Information

Today's Date ___/___/_____ First Name _____ Last Name _____

Street Address _____

City _____ ST ____ Zip _____ SSN _____

Date of Birth ___/___/_____ Gender [Male, Female] Marital Status [Married, Single]

Home Phone _____ Cell Phone _____ Fax _____

Email _____

Permanent or seasonal resident of Southwest Florida? [Permanent, Seasonal]

Primary residence address, if different from above:

Street Address_____City_____ST____Zip_____

Patient Work

Employer _____ Occupation _____

Street Address _____ City _____

ST ___ Zip _____ Phone Number _____

Parent/Guardian/Spouse/Responsible Party

Please complete this section if you are filling this form out on behalf of the patient.

First Name _____ Last Name _____

Street Address _____

City _____ ST ____ Zip _____

Home Phone_____ Cell Phone _____

Emergency Information/Nearest Relative

First Name _____ Last Name _____

Relationship to Patient _____ Street Address _____

City _____ ST ____ Zip _____

Day Time Phone _____ Evening Phone _____

Email Address _____

I/We authorize *Rubino Physical Therapy, Inc.* to release all medical information and/or records to my requesting insurance company and/or referring physician.

_____ _____

Signature of Patient/Guardian Date

Patient Questionnaire

(This information is kept confidential)

Today's Date ___/___/_____ First Name _____ Last Name _____

Date of Birth ___/___/_____ Gender [Male, Female]

Referring Physician _____

From whom or how did you hear about us? _____

History of current condition:

_____

_____

_____

_____

_____

_____

_____

Please lists any medical tests that have been performed, the body part tested, and the results: (ie: X-ray, MRI, Cat Scan)

_____

_____

Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture) Please list practitioners.

What treatment has had a positive effect?

What treatment has had a negative effect?

Have you been advised to have any surgery that has not yet been performed? Please explain.

Please list all previous injuries, accidents and any other medical information pertinent to your treatment:

_____

_____

_____

_____

Please list all medical conditions and/or health concerns:

_____

_____

_____

_____

_____

_____

Please list all current medications:

_____

_____

_____

Please list all allergies:

_____

_____

_____

Please list any surgeries you have had, along with the year in which they were performed:

_____

_____

_____

Please check any symptoms you have or have had in the past year (check all that apply) :

- ☐ Change in bowel movements
- ☐ Irritable bowel
- ☐ Persistent joint pain
- ☐ Blood in bowel/urine

- [ ] Hot flashes
- [ ] Vertigo or dizziness
- [ ] Persistent nose bleeds
- [ ] Difficulty concentrating
- [ ] Learning disabilities
- [ ] Tiredness/fatigue
- [ ] Muscle spasms
- [ ] Fainting spells
- [ ] Eating disorder/difficulty
- [ ] Difficulty Sleeping
- [ ] Other_____

Do you have a history of any of the following? (check all that apply):

- [ ] Head or spinal injuries
- [ ] Recurrent headaches
- [ ] Meningitis
- [ ] Stomach ulcers
- [ ] Heartburn/indigestion
- [ ] Shortness of breath
- [ ] Anemia
- [ ] Asthma
- [ ] Bladder infection
- [ ] Heart Problems
- [ ] Depression
- [ ] Other_____

Dental history (check all that apply):

- [ ] Worn braces
- [ ] Worn a retainer
- [ ] Grind or clench teeth
- [ ] Worn a dental splint
- [ ] Currently wearing a night guard
- [ ] TMJ disorder
- [ ] Popping or clicking in jaw
- [ ] Jaw lock up
- [ ] Other_____

Have you ever been knocked unconscious? [yes, no]

Have you had a concussion? [yes, no]

Have you had any head or spinal injuries? [yes, no]

For Women Only

Number of pregnancies _____ Number of children _____

Date of last pelvic exam ___/___/_____ Date of last pap smear test: ___/___/_____

Do you take birth control?_____ If so, how long have you taken it?_____

Are you pregnant or is there a chance that you could be pregnant? [yes, no]

Please check any symptoms or conditions that apply:

- ☐ Menstrual cycle irregular
- ☐ Pass blood clots
- ☐ Pain and cramping during period
- ☐ Pain with intercourse
- ☐ Back pain
- ☐ Groin pain
- ☐ Pain in lower abdomen
- ☐ Urinary and/or bowel incontinence
- ☐ Menopause
- ☐ Other _____

Please comment on any other information about pregnancies, complications with delivery, menstrual problems, or pain you feel we should know about:

_____

_____

_____

_____

_____

Office Policies & Procedures

Welcome and thank you for choosing Rubino Physical Therapy for your Physical Therapy needs. Florida Law and the State of Florida Physical Therapy Board allows patients to be evaluated and treated by a physical therapist without a prescription for physical therapy for up to 21 days. If PT treatment is required beyond 21 days for a condition not previously assessed by a practitioner of record, the PT shall obtain a practitioner of record who will review and sign the plan. It is beneficial to obtain and maintain a current referral prior to evaluation and during your treatments.

As a courtesy to others and our Therapists and to other patients trying to get scheduled, **we require a 24-hour (or greater) notice for cancellations**. This allows others on waiting lists to be seen. Only emergencies or illnesses are excusable. **A $75 fee will be billed upon violation of this policy.**

Payment & Billing Policies

Rubino Physical Therapy, Inc. is a fee-for-service clinic. This means that payment is due at the time services are rendered and we **will Not** bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may choose submit to your insurance company. If further reports or documentation are requested, these will be provided. We accept cash, personal checks, and credit cards.

Medicare will Not pay for services rendered at Rubino Physical Therapy. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor, healthcare provider, or fitness professional has recommended it. Right now, in your case, Medicare will not pay for our services as we are *not* a Participating Provider with Medicare or any other insurance company, and we only agree to work with Medicare clients for fitness, prevention, and wellness goals
(which are not covered services under Medicare). You will not be able to submit for reimbursement as our services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually posses. Signing below means that you have received and understand this notice. You may receive a copy upon request at any time.

Given you will be paying at the time of services, if your insurance company reimburses our clinic, these monies will be returned to them and a new check must be cut to you personally. We are available for after hours, weekend, and home visits at additional costs. Supplies and additional items are also at additional costs. Please clarify prior to your first treatment if you have any questions regarding charges or fees.

Privacy Policy

I understand that Rubino Physical Therapy, Inc. will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying

out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Consent to Treatment

Rubino Physical Therapy is a hands-on Physical Therapy clinic. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of ultrasound, electrical stimulation, traction, deep tissue massage, therapeutic exercise programs, gait training, neuromuscular re-education, craniosacral therapy, myofascial release, bone and soft tissue manipulation, as well as other treatment modalities may be used. Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern, however, please ask if you have any concerns or questions. The number of treatments needed and recovery time can vary due to the age of injury, number of times injured, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at Rubino Physical Therapy, Inc. I authorize Michael Rubino, DPT, MTC and the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

I have read and completely understand the above written statements.

X_____Date ___/___/_____

Signature of patient/legal guardian

I also understand that Medicare will not reimburse for services rendered by Rubino Physical Therapy, Inc.

X_____Date ___/___/_____

Signature of patient

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Photograph & Video Release Form

Video recordings of our treatments help us get the word out about what we do and how we can help others. They also help us to teach others how to replicate our methods and better help their patients. With that said, please read below and let us know if you'd be okay with us recording and using any part of your treatment sessions.

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied,exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- online educational courses
- educational videos
- for-profit endeavors

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

Signature_____ Date ___/___/_____

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature_____ Date ___/___/_____