OFFICE OF INSURANCE REGULATION
*Bureau of Property & Casualty Forms and Rates*

# Standard Disclosure and Acknowledgement Form
## Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have already been provided.

   Physical Therapy/Occupational Therapy Services
   (List of charges on 1st day) :

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)* | Signature | Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been **upcoded, unbundled,** or constitutes an invalid or **not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand)*:

Name *(PRINT or TYPE)* | Signature | Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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Optimal Physical Therapy

## NOTICE OF INITIATION OF TREATMENT FOR PHYSICAL THERAPY

## (AUTO/PIP CLAIMS)

**Patient:** _____

**Insurance Company:** _____ **Claim#:** _____

To: Claims Department

The Initial Evaluation was conducted by respondent. The initial evaluation for therapeutic services were rendered on _____, respondent provided physical therapy to patient _____ . Therapy was performed for accident or injury first occurred on _____.

We are hereby notifying this patient's insurance company under Florida Law that our facility will be providing therapeutic services to the above named patient for various therapeutic services which may include therapeutic exercise, initial evaluation and/or re-evaluation, electric stimulation, manual therapy, massage, neuromuscular re-education, self-care/home management training, gait training, etc.

**"Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination of treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 days before the postmark date of the statement. The insured has a responsibility to furnish the provider with the correct name and address of the personal injury protection insurer. Failure to do so may result in delayed reimbursement to the provider."**

"(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insured is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. When an insurer pays only a portion of a claim or rejects a claim, the insurer shall provide at the time of the partial payment or rejection an itemized specification of each item that the insurer had reduced, omitted, or declined to pay and any information that the insurer desire the claimant to consider related to the medical necessity of the denied treatment or to explain the reasonableness of the reduced charge, ...

(d) All overdue payments shall bear simple interest at the rate established under s.55.03 or the rate established in the insurance contract, whichever is greater, for the year in which the payment became overdue, calculated from the date the insurer was furnished with written notice of the amount of covered loss. Interest shall be due at the time payment of the overdue claim is made."

Provider Facility: _____

Treating Therapist: _____ Date: _____

Patient Signature: _____ Date: _____

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## LETTER OF PROTECTION FOR

# OPTIMAL PHYSICAL THERAPY, LLC.

I hereby authorize Optimal Physical Therapy, LLC. to furnish you, my attorney, with a full report of his examination, diagnosis treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorized and direct you, my attorney, to pay directly to said rehab center such sums as may be due and owing him for professional services rendered both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said rehab center. I hereby further give lien on my case to said rehab center against any and all proceeds of any settlement, judgement, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated in connection therewith.

I fully understand that I am directly and fully responsible to said rehab center for all professional bills submitted by him for services rendered to me and that this agreement is made solely for said rehab center's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

If my case is referred to another attorney, this authorization must be accepted by him along with all rights and obligations, as described herein; otherwise, the obligations of his authorization rests with you.

In the event of any dispute as to the charge for services rendered, I shall be responsible for all costs of collection to the above-mentioned rehab center, including a reasonable attorney's fee.

**Patient's Signature:** _____ **Date:** _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary adequately to protect the said rehab center named above.

In the event that this case is referred to another attorney, I acknowledge that this authorization must be accepted by him along with all rights and obligations, as described herein, the obligations of this authorization rests with me.

**Attorney's Signature:** _____ **Date:** _____

ATTORNEY: _____

FIRM: _____

ADDRESS: _____

_____

CONTACT: _____ PHONE: _____

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## PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ SEX: MALE FEMALE

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS#: _____ HOME PHONE: _____ CELL NUMBER: _____

MARITAL STATUS: S M D W

EMPLOYER NAME: _____ PHONE: _____

EMPLOYER ADDRESS: _____

NEXT OF KIN: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER: _____ ADDRESS: _____

REFERRING DOCTOR: _____ PHONE NUMBER: _____

INJURY/DIAGNOSIS: _____ INJURY WORK RELATED? YES NO

INSURANCE NAME: _____ POLICY #: _____

POLICY HOLDER NAME: _____ CLAIM #/WC#: _____

DATE OF ACCIDENT (IF APPLICABLE): _____

LAW FIRM NAME (IF APPLICABLE): _____ PHONE: _____

ATTORNEY NAME: _____ CONTACT NAME (IF DIFFERENT): _____

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# PATIENT MEDICAL HISTORY

**Name:** _____ **Age:** _____ **Date of Next Doctor's Visit:** _____

**Are you presently working (circle one)?** Yes No Light Work Load? Regular Work Load?

**Date of Injury?** _____ **Was Onset** ___ Sudden __ Gradual?

**Did The Problem Recently Become Worse?** Yes No

**Check All Problems That Apply:**

- ☐ Headache
- ☐ TMJ
- ☐ Upper Back
- ☐ Lower Back
- ☐ Arm Left Right
- ☐ Leg Left Right
- ☐ Shoulder Left Right
- ☐ Elbow Left Right
- ☐ Wrist Left Right
- ☐ Hand Left Right
- ☐ Finger Left Right
- ☐ Hip Left Right
- ☐ Knee Left Right
- ☐ Ankle Left Right
- ☐ Foot Left Right
- ☐ Toe Left Right
- ☐ Other _____

**Have You Had Any Of The Following Test For This Condition:**

- ☐ X-Ray
- ☐ MRI
- ☐ CAT Scan
- ☐ Bone Scan

**How Did This Problem Begin?**

- ☐ Lifting
- ☐ Twisting
- ☐ Falling
- ☐ Crushing
- ☐ Motor Vehicle Accident
- ☐ Unknown

**Have you Been Hospitalized For This Problem?**

- ☐ Yes When? _____
- ☐ No

- ☐ Other: _____

**Are You Currently Being Seen By Any Of the Following People:**

- ☐ Medical Doctor
- ☐ Speech Therapist
- ☐ Dentist
- ☐ Osteopath
- ☐ Psychiatrist/Psychologist
- ☐ Physical/Occupational Therapist
- ☐ Chiropractor

**Have You Been Diagnosed As Having Any Of The Following Conditions:**

- ☐ Seizures
- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Respiratory Problems
- ☐ Rheumatoid Arthritis
- ☐ Elevated Cholesterol
- ☐ Depression
- ☐ Heart Disease
- ☐ Cancer
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ GI Problems
- ☐ Other Arthritic Conditions
- ☐ Diabetes

**Do You Smoke?** YES or NO **Are You Pregnant?** YES or NO

**Do You Lead A Sedentary Lifestyle?** YES or NO

**Have You Ever Had A Fracture Or Dislocation?** YES or NO

**Circle One:** Left Handed or Right Handed

**Do You Have Any Of The Following In Your Body:**

- ☐ Rods
- ☐ Pins
- ☐ Plates
- ☐ Staples
- ☐ Artificial Joints
- ☐ Metal
- ☐ None

**List Any Current Medications Or Recent Injections:** _____

**Please List Any Allergies To Drugs:** _____

**Patient Signature:** _____

**Date:** _____

# PATIENT FINANCIAL POLICY AND AGREEMENT

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims provided verification of your insurance policies allows assigned benefits and coverage for the services rendered.

Please read the following statements carefully. By signing below you agree that you have read and fully understand all statements contained herein.

I, the undersigned, understand that Optimal Physical Therapy, LLC. will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make payment for services rendered, I am fully responsible for all charges incurred, and will pay in full for all services. I understand that I am responsible for payment of any and all deductibles, and/or co-insurance amounts and the charges incurred are not subject to any fee schedule or reductions made by my insurance carrier. I also understand that if my treatment is due to an injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payment of the fees are not contingent upon settlement of a litigation; however, I hereby instruct my attorney to pay Optimal Physical Therapy, LLC. in directly from the proceeds from any settlement or judgment rendered on my behalf.

## EXPLANATION OF MEDICARE BENEFITS

Accepting assignment means that the provider of services agrees to accept the allowable charges as determined by Medicare as full payment. However, Medicare pays 80% if the allowable charges, therefore you are responsible for the 20% balance. In addition to the 20% you are also responsible for any amounts applied toward your annual Part B deductible and any non-covered charges.

## SUPPLEMENTAL COVERAGE/CO-PAYMENT

Optimal Physical Therapy, LLC. has explained to me that under Medicare guidelines, I will be responsible for the 20% of the allowable charge. As Optimal Physical Therapy, LLC. has agreed to accept assignment of benefits on this portion of the charges also, I understand that should the supplemental insurance company fail to pay for these charges within a "reasonable length of time", or send payment directly to me, I will become responsible for payment in full.

## WORKER'S COMPENSATION COVERAGE

Optimal Physical Therapy, LLC. agrees to treat and bill worker's compensation for preauthorized work related injuries per the Worker's Compensation Guidelines for the State of Florida. However, if for any reason Worker's Compensation denies liability for the treatment of the injury, I understand that I become responsible for full payment of the charges.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I, the undersigned, hereby consent to such treatment by the authorized personnel of Optimal Physical Therapy, LLC. as may be dictated by prudent medical practices of my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

The undersigned certifies that the information given by me in applying for payment under the Title XVII of the Social Security act is correct. I, the undersigned, authorize Optimal Physical Therapy, LLC. to release information regarding m health care to the Social Security for this or a related claim. I authorize payment form Medicare to be made directly on my behalf.

I hereby instruct and direct that _____, my Supplemental/Commercial Insurance pay by check made out and mailed to:

*Optimal Physical Therapy, LLC.*
3633 Cortez Road West, A4
Bradenton, FL 34210

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment is not to exceed my indebtedness to the above-mentioned assignee and I have agreed to pay any balance of the said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ _____
Signature of Policy Holder Date

_____ _____
Signature of Claimant, if other than Policy Holder Date

_____ _____
Witness Date

# CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

I hereby authorize Optimal Physical Therapy , LLC. through its appropriate personnel, to perform or have performed upon me or the above named patient, appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.

I further authorize Optimal Physical Therapy , LLC. to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Signature:_____ Date: _____

Relationship to patient: Self Guardian Other

# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

## PLEASE REVIEW IT CAREFULLY

The federal government passed a new law in August 1996 dealing with the privacy of patient records. The new law is called Health Insurance Portability and Accountability Act. HIPAA for short. This is our general consent form. Again review it carefully.

*Health Information Uses and Disclosures*
In our medical practice, we routinely record, use and disclose your health information in order to treat and to assist other healthcare providers in treating you. We also use and disclose your healthcare information in order to obtain payment for our services.

*Permitted Uses and Disclosures Without Your Consent or Authorization*
We may need to disclose your health information without your authorization in the following situations:

- To contact you by telephone or mail to remind you of appointments or to respond to your questions.
- To family members or close friends who are involved in your healthcare.
- If we are providing healthcare services to you in an emergency.
- If there are substantial barriers in communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- For purposes of public health and safety, such as to the FDA to report defects or incidents.
- To Government agencies for the purposes of their audits, investigations, and other oversight activities.
- For research purposes of a limited nature in a limited manner.
- For providing benefits under Worker's Compensation.
- To the law enforcement authorities to assist and or apprehend criminal offenders.
- To Government agencies for prevention of child abuse and domestic violence.
- When required by law, search warrants, subpoenas, or court orders.

*Our Privacy Pledge*
We have and always will respect your privacy. We will not use or disclose your health information without your prior written authorization, other than the uses and disclosures we describe above.

*Your Right To Revoke Your Authorization*
You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we received your request to revoke your authorization.

2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information. If they decide to contest any of your claims, your revocation authorization must be submitted to our office in writing.

*Your Right to Limit Uses or Disclosures*

If there are healthcare providers, hospitals, employers. or other individuals or organizations to which you do not want to disclose your information, it must be submitted in writing.

*Your Patient Rights*

As a patient, you have the following rights:

- To receive a copy of the Notice of Privacy Practices.
- To obtain access to and/or a copy of your health information.
- To request that we communicate with you confidentially by reasonable alternative means.
- To request how we handle or disclose your health information.
- To request amendments to your health information.
- To request an accounting of certain disclosures which we have made of your health information.

You also have the right to write or call to submit a complaint to:

Florida Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308
1-888-419-3456
Or
1-800-962-2873

I acknowledge that I was provided a copy of the Notice of Privacy Practices from the Optimal Physical Therapy, LLC. for me to keep and I have had an opportunity to read and understand the notice. This acknowledgement is requested per Government Statute.

Patient Name (Please Print) _____

Parent or authorized representative _____

Signature _____

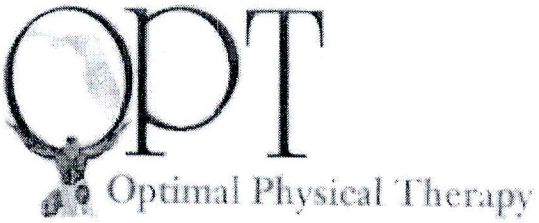
Date _____

Optimal Physical Therapy

# LIST OF MEDICATIONS

Patient's Name:
Date:

| Medications | Dosage | Frequency |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |




# NO SHOW AND CANCEL POLICY

As a courtesy to others, please notify us within 24 hours in advance if you need to cancel your appointment so another patient can be seen.

If you have two consecutive NO SHOW or four CANCELLED appointments you will be discharged from therapy and will require a new script from your doctor.

If you do not show or call to cancel a scheduled appointment within 24 hours in advance, we will notify your physician and or your attorney.

Thank You,

The Staff of Optimal Physical Therapy

I have read and understand and agree to the above statement.

Patient Name:_____

Patient Signature:_____

Employee Signature:_____

Date:_____