PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

SEX: MALE \ FEMALE

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____

EMERGENCY CONTACT: _____

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): _____

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 Tests For This Condition:

_ X-Ray
_ MRI
_ CAT Scan
_ Bone Scan

Have you been hospitalized for this
_ Yes When? _____
_ No

How Did This Problem Begin?

_ Lifting
_ Twisting
_ Crushing
_ Unknown

_ Other _____
_ Falling
_ Motor Vehicle Accident

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
____ High Blood Pressure
____ GI Problems
____Other Arthritic Conditions
____ Diabetes
____ Pacemaker

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 Recent Surgeries: _____, _____, _____

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 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.

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% of 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 COVERRAGE/CO-PAYMENT

Optimal Physical Therapy, LLC has explained to me that under Medicare guidelines, I will be responsible for 20% of the allowable charge as well as all copays and/or deductibles.

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 release information regarding my health care to the Social Security for this or a related claim. I authorize payment from 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 the following:

Optimal Physical Therapy, LLC
3633 Cortez Road West, Suite 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**

Irrevocable Lien

I hereby authorize Optimal Physical Therapy, LLC to furnish to me, my insurance company and or my attorney, with a full report of his or her examination, diagnosis, treatment, prognosis etc. of myself regarding the injuries and treatment in which I have received.

I hereby authorize my insurance company to pay for services directly to said rehab center such sums as may be due and owed for professional services rendered. I recognize that, as the patient, I am responsible for all copays, deductibles and or co-insurance costs to be paid to said rehab center.

I understand that I am directly and fully responsible to said rehab center for all professional bills incurred for professional services provided and this lien is to be used solely for said rehab center's additional protection for any outstanding bills that may be outstanding.

If I am treating due to an injury or injuries sustained due to an automobile accident or premise liability accident, I recognize and understand that legal representation will receive an explanation of benefits and or billing ledger for services rendered. If my legal representation is relieved of duties or ceases to represent me, it is my responsibility as the patient to inform said rehab center of any changes.

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 or my insurance is dropped, I am fully responsible for all charges incurred, which may include copays, co-insurances and or deductibles.

In the event of any dispute as to charges for services rendered, I am responsible for all costs of collections to said rehab center, including reasonable legal fees.

I request that Optimal Physical Therapy submit bills/charges to the following:

Please mark all that apply:

___ Commercial Medical Insurance

___ Medicare

___ Workers' Compensation Insurance

___ Automobile Insurance

___ VA

___ I have obtained legal representation.

If marked, please provide:

Firm Name: _____

Address: _____

Phone: _____

Patient Signature: _____ Date: _____

Rehab Center Signature: _____ Date: _____

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. HIPPA 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 assess 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 have described 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. 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 the following:

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 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

_____ _____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Hereby authorize Optimal Physical Therapy, LLC through 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.

Date: _____

Signature _____

Relationship to Patient: Self Guardian Other

INSURANCE REQUIREMENT

LIST OF MEDICATIONS

Patient Name: _____

Date: _____

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

OPT
Optimal Physical Therapy

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, understand, and agree to the above statement.

Patient Name: _____

Patient Signature: _____

Employee/Staff Signature: _____

Date: _____