OPTIMUM
PHYSICAL THERAPY AND
PERFORMANCE CENTER

PATIENT NAME:_____ **DOB:**_____ **DATE:**_____

PAST MEDICAL HISTORY

1. **Do you currently, or have you in the past had the following:**

Diabetes	**[Y] [N]**	**Bladder/Bowel Problem**	**[Y] [N]**	**Osteoporosis**	**[Y] [N]**
Hypertension	**[Y] [N]**	**Blood Clot/Emboli**	**[Y] [N]**	**HIV/AIDS**	**[Y] [N]**
Cancer	**[Y] [N]**	**Kidney /Liver Disease**	**[Y] [N]**	**Psychological Problems**	**[Y] [N]**
Seizure/Epilepsy	**[Y] [N]**	**Gout**	**[Y] [N]**	**Stroke/TIA**	**[Y] [N]**
Heart Condition	**[Y] [N]**	**Headaches**	**[Y] [N]**	**Thyroid Problems**	**[Y] [N]**
Hepatitis	**[Y] [N]**	**Weight gain/loss**	**[Y] [N]**	**Tuberculosis**	**[Y] [N]**
Respiratory problem	**[Y] [N]**	**Pacemaker**	**[Y] [N]**	**Vision Problems**	**[Y] [N]**
Chest Pain	**[Y] [N]**	**Currently Pregnant**	**[Y] [N]**	**Do you Smoke?**	**[Y] [N]**
Falls in past year	**[Y] [N]**	**Sleep Problems**	**[Y] [N]**	**Other**	

HEIGHT: _____ **WEIGHT:**_____

2. **Please list any allergies:**_____
3. **Do you currently have assistance at home? Yes No**
4. **Living environment: Stairs Y N Railing Y N Ramp Y N**
5. **Hand dominance? Right Left**
6. **Please indicate any prior Orthopedic injury/surgeries (procedure/date):**
   Shoulder:_____ **Wrist/ Elbow:**_____
   Hip:_____ **Knee/Ankle:**_____
   Lower Back:_____ **Neck:**_____
7. **Other Surgeries:** _____
8. **Please list all Current Medications (Including "over the counter medicines and supplements): [ ] see list.**

MEDICATION	DOSAGE/METHOD (i.e. by mouth, injection)	FREQUECY

Patient Signature:_____ **Date:**_____

Reviewed by Physical Therapist : initial_____ **Date:**_____

9. **Please circle any of the following whose care you are under:**
   Medical Doctor Pain Physician Neurologist Chiropractor
   Osteopath Orthopedic Psychologist/Psychiatrist Other
10. How did you hear about Optimum Physical Therapy and Performance Center? Website_____
    Physician_____ Relative/Friend_____ Insurance_____ Sign_____ Other_____
11. **What are your goals for therapy?**_____

_____

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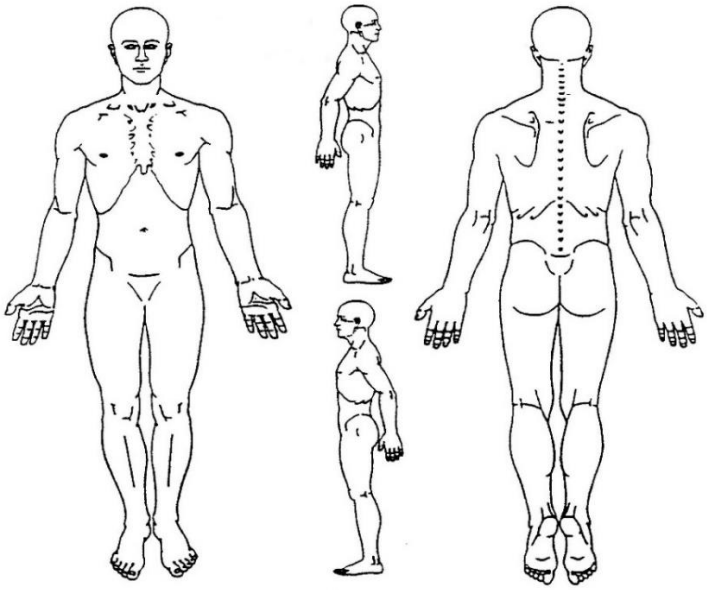
CURRENT CONDITION

1. **Please describe the onset of your symptoms/injury (when, how?):**_____
   _____
2. **Prior history of similar condition?**_____
3. **Which, if any, medical tests have you had performed for *this* condition (circle): MRI X-Ray EMG CT Scan Arthrogram MRA EKG**
4. **Have you had surgery for this condition? Y N Type**_____ **Date**_____
5. **Have you received injections for this condition? Y N Date(s):**_____
6. **Did the injections help? Y N Some**
7. **What increases/worsens your symptoms?**_____
   _____
8. **What reduces/improves your symptoms?**_____
9. **Currently, symptoms are: Constant Intermittent Rare**
10. **Please indicate your type, location and severity (0-10) of pain on the drawing below: A=Ache, B=Burning, N=Numb, T=Tingling/pins and needles, S=Sharp/Stabbing, H=Shooting, D=Dull, O=other**



0-10 Numeric Pain Rating Scale

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PLEASE INITIAL EACH SECTION

INFORMED CONSENT FOR TREATMENT:

I/we hereby authorize to receive care at Optimum Physical Therapy and Performance Center, LLC (Optimum PTPC**).** Physical therapy evaluation and treatment involves certain inherent risks. Patients are asked to exert effort and perform activities and exercises with increasing degrees of difficulty. These risks may include, but are not limited to cardiovascular, muscle, ligament, joint or disc injury. Symptomatic aggravation of your current condition is also possible. Risk factors have been reduced to the best of our ability; however, any increase in your current level of discomfort, or any other change in your symptoms should be immediately reported to a staff member.

In accordance with the APTA Guidelines, information provided to the patient shall include the following:

- A clear description of the treatment ordered or recommended
- Expected benefits of treatment
- Material (decisional) risks associated with the proposed treatment
- Reasonable alternatives to the recommended treatment
- Comparison of the benefits and risks possible with and without treatment

If you have any questions on the above, please feel free to ask your therapist.

The above items have been discussed with me to my satisfaction and I understand and consent to the planned physical therapy treatment.

NAME:_____**DATE OF BIRTH**:_____**INITIAL:_____**

ATTENDANCE POLICY

We are pleased to have the opportunity to provide rehabilitation services for you at Optimum PTPC. One vital component to obtain optimal outcomes from your rehabilitation is consistent compliance with your therapy appointments as well as your assigned home exercise program. In some cases, consistent attendance is a requirement for payment by your insurance provider/employer (as applicable). We expect that you arrive on time for your scheduled appointments. If you arrive 15 minutes late or more, your appointment may be rescheduled depending on your therapist's schedule. If you do not believe your rehabilitation program is accomplishing your goals, please discuss this with your therapist or clinical director immediately so proper adjustments may be made.

In the event you are unable to keep a scheduled appointment or participate in your program, you are to notify us prior to the scheduled appointment or program time. Our clinic may inform your referring physician, employer, insurance provider, case manager or rehabilitation nurse of your absence as required. If two subsequent absences occur without notice from you for the reason for absence, rehabilitation may be discontinued due to non-compliance related to attendance. Please understand that if you experience increased symptoms, your therapist needs to see you to treat your symptoms and modify the plan of care as necessary. **We request 24 hours advanced notice if you are unable to keep or attend your scheduled appointment. In the event of a no show or cancellation of an appointment with less than 24 hours, you may be charged a $50 fee for the missed appointment.**

_____ **INITIAL:_____**

ASSIGNMENT & RELEASE (For All Patients)

I, the undersigned, assign directly to Optimum PTPC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the physical therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I also understand that if I have a co-pay it will be due at the time of service. Medicare Authorization: I request that payment of authorized Medicare or Medigap benefits be made on my behalf to Optimum Physical Therapy and Performance Center, LLC, for any services furnished to me by a physical therapist. I authorize Optimum PTPC to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the medical provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. **NOTE: Medicare has placed a $2040 cap on outpatient rehabilitation coverage for the year. If you have had prior physical therapy and/ or speech therapy visits in 2019, please inform us. I certify that the information provided to Optimum PTPC for payment under the Social Security Act (Medicare) including but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

_____**INITIAL:_____**

PAYMENT POLICY

Optimum PTPC will bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill is an agreement between you and Optimum Physical Therapy and Performance Center, LLC. It is ultimately your responsibility to see that your physical therapy bill is paid in full. Agreements with insurance companies vary greatly and it is your responsibility to know what portion is deemed the responsibility of the insurance payer and what portion is your responsibility as the patient. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Optimum PTPC within 5 weeks, it will be your responsibility to contact the insurance provider. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company informed us is your portion to pay upon verification. We expect this payment within 30 days. IF PAYMENT IS NOT RECEIVED WITHIN THIS 30-DAY PERIOD, A FINANCE CHARGE WILL BE ASSESSED PER MONTH. IN THE EVENT A CHECK IS RETURNED FOR ANY REASON, A $50.00 CHARGE WILL BE MADE TO YOUR ACCOUNT. YOU AGREE TO PAY ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEYS' FEES, INCURRED IN THE COLLECTION OF PAST DUE ACCOUNTS. Amounts turned over for collection will be subject to 25% collection fee. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of medical necessity. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. The parents (or guardians) accompanying a minor are responsible for payment of the minor's treatment.

_____**INITIAL:_____**

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered the Optimum Physical Therapy and Performance Center, LLC, notice of Privacy Practices.

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By signing below, I acknowledge that I have read and agree with Optimum Physical Therapy and Performance Center's Informed Consent for Treatment, Attendance Policy, Assignment and Release, Medicare Authorization (if applicable), Payment Policy, and Acknowledgement of Privacy Practices

Patient Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

If Patient is a minor, to be signed by Parent or Guardian

Printed Name of Parent or Guardian:_____