opti orthopedic physical therapy institute

Patient Information- (Please Print Clearly)

Patient Name:	Date of Birth:	Age:	Sex: F / M
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	Email:
SS#:	Driver's License #:	Marital Status: M / S / W / D	Name of Spouse:
Emergency Contact Name:		Relationship:	Phone Number:
Employment Status:	Occupation:		Employer:
Employer Contact:	Employer Contact Phone Number:		Student- School Name

Treatment Payment/ Insurance: ❑ Medicare ❑ Private Insurance ❑ Auto Medical ❑ Self

❑ Work Comp.(Date of Injury_____) Adjuster/Case Mgr. Name_____

Telephone#_____ Case#_____

❑ Lien Attorney Name and Company: _____ Phone Number: _____

Insurance Name_____ID#_____Group#_____
Subscriber Name_____ ____Subscriber Date of Birth_____
Subscriber Relationship to Patient_____S.S.#_____

***** Have you been a patient here before? Yes or No (Circle one)***

How did you hear about us?

1. Doctor: _____
2. Family Member / Friend: _____
3. Insurance: _____
4. Internet Search: _____
5. Other: _____

REFERRING DOCTOR SECTION:

Name of Doctor who referred you: _____

Date of your follow up visit with this Doctor: _____

(Note: This date is needed so that we can send a progress report before this appointment)

NOTICE OF PATIENT INFORMATION PRACTICES
THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED, AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL DUTY
Orthopedic Physical Therapy Institute, Inc. (OPTI Physical Therapy) is required by law to protect the privacy of you personal information, provide this notice of our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION
Orthopedic Physical Therapy Institute, Inc. (OPTI Physical Therapy) will use your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Orthopedic Physical Therapy Institute, Inc. (OPTI Physical Therapy) may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest to you.

Orthopedic Physical Therapy Institute, Inc. (OPTI Physical Therapy) may also use or disclose your personal information without prior authorization for public health purposes, and for emergencies. We also provide information when required by law.

In any situation, Orthopedic Physical Therapy Institute's (OPTI Physical Therapy) policy is to obtain written authorization before disclosing your personal health information. If you provide us with a written authorization to release information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Orthopedic Physical Therapy Institute, Inc. (OPTI Physical Therapy) may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room, patient exam areas, and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information in your records. You also have the right to request a list of instances where we have disclosed your personal information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we do not use or disclose your personal health information for treatment, payment and administrative purposes, except when specifically authorized by you, when required by law, or in emergency circumstances. Orthopedic Physical Therapy Institute, Inc. (OPTI Physical Therapy) will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS
If you are concerned that Orthopedic Physical Therapy Institute, Inc. (OPTI Physical Therapy) may have violated your privacy rights, or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address below.

For further information on Orthopedic Physical Therapy Institute, Inc. (OPTI Physical Therapy) health information practices, or if you have a complaint, please contact our practice management at the address below

Orthopedic Physical Therapy Institute 4028 Dale Rd., Suite 101Phone: (209)312-9739 Fax: (209)312-9747

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, _____, herby consent to the therapeutic procedures outlined below, to be performed by Orthopedic Physical Therapy Institute, Inc.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.
- I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, and ultrasound, and special procedures such as: taping, neuromuscular electrical stimulation. I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and
- that I may refuse any therapeutic procedure or treatment at any time.
  I understand that I may consult with other therapists and/or physicians at any time regarding my condition.
- I understand that I may purchase exercise equipment from Orthopedic Physical Therapy Institute, Inc. or from any
- other source.

I certify that I have read, and understand, the above consent statements:

Patient's Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY POLICY

I hereby agree to pay my account AS SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through Orthopedic Physical Therapy Institute, Inc.'s billing department. These arrangements must be completed within 10 days of my initial visit to the office.

I hereby assign all physical therapy benefits to Orthopedic Physical Therapy Institute, Inc. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY OPTI, THEN I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO THE SERVICES PROVIDED. This includes, but not limited to, services deemed 'non-covered' or 'not medically necessary' by my insurance.

Although I have requested Orthopedic Physical Therapy Institute, Inc. to bill my insurance company on my behalf, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE DIRECTLY TO Orthopedic Physical Therapy Institute, Inc. FOR MY ACCOUNT REGARDLESS OF THE STATUS OF MY INSURANCE CLAIM.

PATIENT'S SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent/Authorized Representative (if applicable): _____ Date: _____

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HEALTH HISTORY

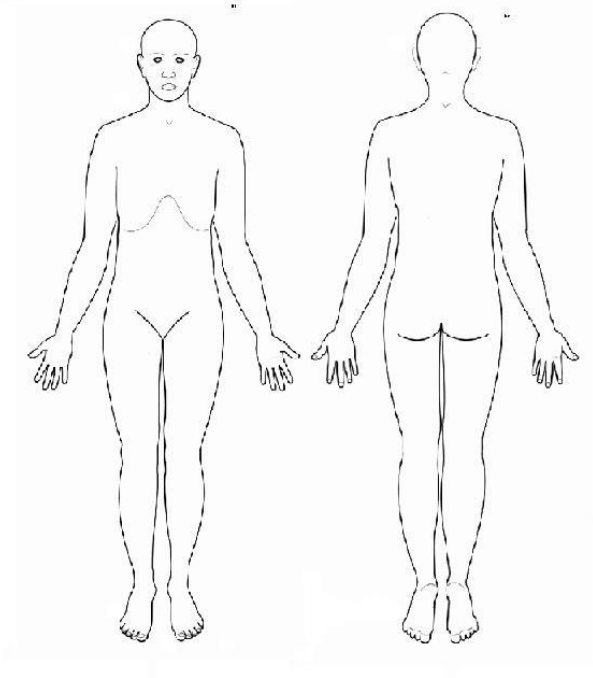
To insure that you receive a complete and thorough evaluation, please provide us with the most accurate, important, and up-to-date background information. Thank you. OPTI

Name: _____Date:_____

PRESENT CONDITION

Please briefly describe your symptoms: _____
_____
_____

Please localize your **pain** or **abnormal** symptoms/ sensations by marking on the body diagram below.



Pain Scale: 1 2 3 4 5 6 7 8 9 10

When did you first notice symptoms: _____

*Did your symptoms begin **gradually** or **suddenly**?*
(circle one)

How did your injury occur (if you have had surgery, please answer according to your pre-operative injury):

- ☐ lifting
- ☐ a MVA (car accident)
- ☐ a fall
- ☐ overuse (cumulative trauma)
- ☐ degenerative process
- ☐ during recreation/sports
- ☐ an impact injury
- ☐ a dental appointment
- ☐ throwing
- ☐ an incident at work
- ☐ unknown
- ☐ running
- ☐ other:_____

Please list any recent/relevant surgeries or hospitalizations:

Surgery/Hospitalization Date

_____
_____
_____

***Since the onset of your condition, are your symptoms getting*:**

☐ better ☐ worse ☐ no change

Have you experienced similar symptoms in the past? ☐yes ☐ no

More than one episode? ☐ yes ☐ no

Nature of pain/symptoms:

- ☐ aching
- ☐ throbbing
- ☐ periodic
- ☐ dull
- ☐ occasional
- ☐ constant
- ☐ other
- ☐ sharp

As your day progresses, do your symptoms:

☐ increase ☐ decrease ☐ stay the same

Does the pain wake you at night?

☐ yes ☐ no

Since the onset of symptoms, have you experienced one of the following: *(Check all that apply)*

- ☐ difficulty controlling bowel or bladder function
- ☐ fever or chills
- ☐ numbness
- ☐ any dizziness or fainting attacks
- ☐ weakness
- ☐ unexplained weight change (loss or gain)
- ☐ night pain/sweats
- ☐ malaise (vague feeling of bodily discomfort)
- ☐ problems with vision/hearing

What aggravates your symptoms? *(Check all that apply)*

- ☐ sitting
- ☐ going to/rising from sitting
- ☐ lying down
- ☐ walking
- ☐ up/down stairs
- ☐ reaching overhead
- ☐ reaching in front of body
- ☐ reaching behind back
- ☐ reaching across body
- ☐ talking, chewing, yawning
- ☐ recreation or sports
- ☐ repetitive activities
- ☐ household activities
- ☐ standing
- ☐ squatting
- ☐ sleeping
- ☐ coughing/sneezing
- ☐ taking a deep breath
- ☐ looking up overhead
- ☐ swallowing
- ☐ stress
- ☐ sustained bending
- ☐ other _____

What eases your symptoms? *(Check all that apply)*

☐ sitting ☐ walking
☐ heat ☐ exercise
☐ cold ☐ lying down
☐ stretching ☐ massage
☐ wearing a splint/orthotic ☐ medication
☐ rest ☐ other_____
☐ standing

What type of treatment have you had for this condition?

☐ medication ☐ muscle/skin injections
☐ joint manipulation ☐ chiropractor
☐ exercise ☐ physical therapy
☐ massage therapy ☐ biofeedback
☐ traction ☐ TENS unit
☐ bracing/taping ☐ other_____
☐ spinal injection

Have you had any of the following tests for this condition?

☐ X-ray ☐ Bone scan
☐ CT scan ☐ Nerve Conduction Test
☐ MRI ☐ Fluroscope
☐ Arthrogram ☐ Vestibular
☐ Stress test x-ray(Telos) ☐ Other_____

Test results: _____

MEDICATION

Please list any and all ***prescription*** *medication you are currently taking for this condition:* _____
_____
_____

Are you currently taking any of the following over-the-counter medications:

☐ Aspirin ☐ vitamins/mineral supplements
☐ Tylenol ☐ Advil/Motrin/Ibuprofen
☐ corticosteroids ☐ other_____
☐ antihistamines

GENERAL HEALTH

How would you rate your general health?

☐ excellent ☐ average ☐ poor
☐ good ☐ fair

Do you exercise outside of normal daily activities?

☐ 5+ days/week ☐ occasionally
☐ 3-4 days/week ☐ I do not work out
☐ 1-2 days/week

What kind of athletic or recreational activities do you perform?

_____
_____

Are you currently employed? ☐ yes ☐ no

Occupation:_____

Do you smoke?

☐ yes ☐ no ☐ *packs per day:*_____

Are you pregnant?

☐ yes ☐ no ☐ m*onths:*_____

MEDICAL HISTORY

Personal medical history:

☐Cancer ☐ Heart Conditions
☐ Depression ☐ Stroke
☐ Lung Problems ☐ Diabetes
☐ High blood pressure ☐ Arthritis
☐ Thyroid problems ☐ Allergies
☐ Epilepsy/Seizures ☐ Head injury
☐ Multiple Sclerosis ☐ Rheumatoid
☐ Mental/behavioral disorders ☐ Osteoporosis
☐ Parkinson ’s disease ☐ Fibromyalgia
☐ Stomach problems ☐ Broken bone
☐ Circulation/vascular problems ☐Other_____
☐ Infectious diseases: _____

Have you been exposed to:

☐ HIV/AIDS ☐ Tuberculosis ☐ Hepatitis

Family or primary care physician:

_____

I, the undersigned, state that I have answered this health history completely and to the best of my knowledge:

_____
Signature

_____
Date

PATIENT COMMITMENT & MISSED APPOINTMENT POLICY

Dear Patient:

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something every one in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

It is expected that you keep all your scheduled appointments.

A 24 hours notice is required for an appointment to be rescheduled. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. This appointment needs to be in the same week of the original appointment, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge a $ 25 fee.

The only exception to the cancellation fee is in the case of an emergency. If repeated cancellations, we reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We greatly appreciate you as a patient and strive to accomplish wonderful results and success for you.

Sincerely,

Orthopedic Physical Therapy Institute, Inc.

I certify that I have read and understood the above policy:

Print Name: _____ Date: _____

Signature: _____ Date: _____