Welcome to

OPTIMUM PHYSICAL THERAPY

PATIENT INFORMATION

Date_____

Name_____SSN_____DOB_____ M__F___

Address_____City _____State_____Zip Code_____

HomePhone_____Cell Phone_____Email_____

Wk Phone_____Emergency Contact Name:_____Phone:_____

INSURANCE INFORMATION

Primary Ins. Co._____Policy #_____Group#_____

Secondary Ins. _____Policy#_____Group#_____

REFERRAL INFORMATION

How did you hear about us? _____Doctor _____Ad _____Family/Friend_____
Other_____

Physician_____

Please list the family members or other persons whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and healthcare needs):

_____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
NAME	RELATIONSHIP	PHONE NUMBER

Experience you can trust
Results you can count on

PAST MEDICAL HISTORY

Name_____ Date_____

HAVE YOU EVER HAD THE FOLLOWING CONDITIONS (please check)

	YES	NO		YES	NO		YES	NO		YES	NO
Heart Trouble	___	___	High Blood Pressure	___	___	Smoking	___	___	Pacemaker	___	___
Diabetes	___	___	Bleeding Disorder	___	___	Stroke	___	___	Arthritis	___	___
Headaches	___	___	Tuberculosis	___	___	Cancer	___	___	Asthma	___	___
Dizzy Spells	___	___	Osteroarthritis	___	___	Fracture	___	___	Back Injury	___	___
Fainting Spells	___	___	Hepatitis	___	___	Epilepsy	___	___	Emphysema	___	___

Other conditions_____

Date of Injury/Condition:_____ How did the injury occur?_____

Have you had surgery for the present problem? Yes:_____ date:_____ No:_____

Last seen by physician for problem? _____ Next M.D. appt. date: _____ Are you seeing any other physicians? _____

Please list any medications you are currently taking_____

Surguries_____

PAIN DRAWING

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate types of symptoms.

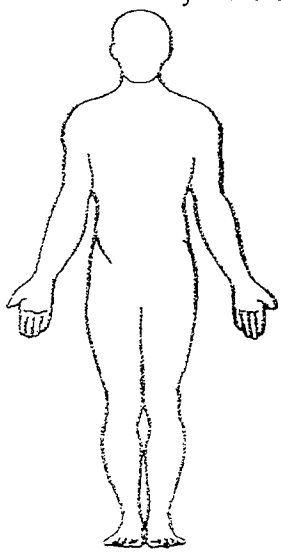
KEY:

Pins and needles = 00000

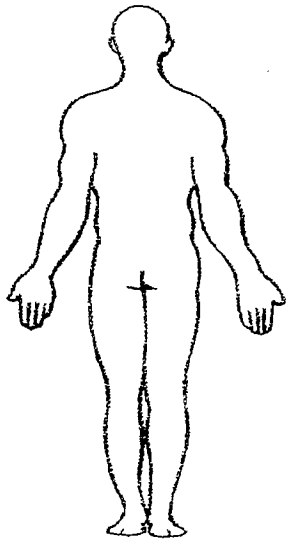
Stabbing = //////

Burning = XXXXX

Deep Ache = ZZZZZ



Front



Back

Please use the three scales below to rate your pain over the past 24 hours. Use the upper line to describe you pain right now. Use the other scales to rate your pain at its worst and best over the last 24 hours.

RATE YOUR PAIN	0 = No Pain										10 = Extremely Intense
Right Now	0	1	2	3	4	5	6	7	8	9	10
At Its Worst	0	1	2	3	4	5	6	7	8	9	10
At Its Best	0	1	2	3	4	5	6	7	8	9	10

OFFICE/FINANCIAL POLICY

INITIAL
PLEASE

_____1. We will bill your insurance company once your insurance coverage has been verified. You are responsible for any co-payment, deductible, or responsibility of cost percentage at the time of service. If your insurance fails to pay within 60 days of the date of service, we will expect you to pay the balance in full, and seek reimbursement from your insurance company.

_____2. When you are paying cash for your visit, payment in full is expected at time of service. We are willing to discuss payment plans if necessary.

_____3. I am responsible for all charges regardless of my existing medical coverage or paymnent plan. If payment is forwarded to me, I will forward payment to you. If the account becomes past due, the balance becomes my responsibility and is immediately due. I also agree to pay all collection costs incurred, in an amount not to exceed 50% of the unpaid balance. Should any unpaid balance be referred to a collection agency or referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

_____4. I hereby authorize the above provider to render any and all therapy services or other related service, that the provider feels are necessary or advisable to the patient in conjunction with the physician's referral.

_____5. I assign payment of medical benefits directly to the provider.

_____6. I authorize the release of any medical information necessary to process this claim to insurance company representatives. I also give my authorization to release my records, progress notes and verbal reports if/when needed. I also authorize the request of an appeal or a fair hearing with my insurance or Medicare carrier if payment is denied.

_____7. If you are unable to attend your scheduled appointment you must notify the office in advance of your appointment time. <u>OPTIMUM Physical Therapy reserves the right to discharge you after you no-show/cancel 3 appointments.</u> Both you and the therapist's time is important. Please be on time. If you are being seen under worker's compensation or a medical lien, case worker or attorney will be notified of your missed appointments.

I have read and understand OPTIMUM Physical Therapy's Office/Financial Policies.

_____ _____

PRINTED NAME SIGNATURE

_____

DATE