Optimum Performance Physical Therapy, LLC

Patient Information:

Name: _____DOB: _____SS# _____

Address: _____

Phone: (H) _____ (W) _____(C) _____

Sex: Male _____Female _____Marital Status: M S D W Email: _____

Employer Name/ Address: _____

Referring Physician: _____(P) _____

Primary Care Physician: _____(P) _____

Body Part: _____ Injury: _____ Surgery: _____

Insurance Information:

Primary Insurance: _____ Policy # _____ Group # _____

Policy Holder: _____ DOB: _____SS# _____

Phone # _____

Secondary Insurance: _____Policy # _____ Group # _____

Policy Holder: _____ DOB: _____SS# _____

Phone # _____

WKCP (Worker's Compensation)

Carrier's Name: _____ DOI: _____ Claim #: _____

Billing Address: _____

Adjuster: _____ (P) _____ Referring Physician: _____

How did injury occur: _____ Surgery: _____ Type of Surgery: _____

MVA (Motor Vehicle Accident)

Name of Auto Insurance: _____ DOA: _____ Claim #: _____

Billing Address: _____

Were they seen anywhere after the accident: _____

I have reviewed the above information, other than any changes indicated above; I found the information to be correct. I have been informed of the coverage verified and understand that this is only a verbal verification of benefits, not guarantee of payment by my insurance company. This is not a guarantee of payment. We encourage you to independently verify you own insurance.

Patient Signature: _____ (seal) Date: _____

Optimum Performance Physical Therapy, LLC

To ensure you receive a complete and thorough evaluation, please provide us with the most accurate, important, and up to date background information

Name: _____ **Date:** _____

Occupation: _____ **Employer:** _____

Date of injury or onset: _____ **Date of Surgery:** _____ **Type of Surgery:** _____

Briefly describe your symptoms: _____

Dominant side: [ ] Right [ ] Left **Involved side:** [ ] Right [ ] Left

How did your injury occur:

[ ] Work incident [ ] Fall [ ] Carrying [ ] MVA
[ ] Recreation/sports [ ] Throwing [ ] Pushing [ ] Impact injury
[ ] Home injury [ ] Trauma [ ] Pulling [ ] Running
[ ] Degenerative process [ ] Lifting [ ] Overuse [ ] Infection
[ ] Unknown Other: _____

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

[ ] Angiogram [ ] Doppler ultrasound [ ] MRI [ ] Stool test
[ ] Arthroscopy [ ] Echocardiogram [ ] Myelogram [ ] Stress test
[ ] Biopsy [ ] EEG [ ] NVC [ ] Stress x-ray
[ ] Blood tests [ ] EKG [ ] Pap smear [ ] Urine test
[ ] Bronchoscopy [ ] EMG [ ] Pulmonary function test [ ] X-rays
[ ] CT scan [ ] Mammogram [ ] Spinal tab Other: _____
Test Results: _____

Nature of pain/symptoms:

[ ] Aching [ ] Numbness & tingling [ ] Radiating [ ] Throbbing
[ ] Burning [ ] Occasional [ ] Shooting [ ] Other: _____
[ ] Constant [ ] Periodic [ ] Stabbing
[ ] Dull [ ] Pins & needles [ ] Sharp

As the day progresses do symptoms: [ ] Increase [ ] Decrease [ ] Stays the same

Do symptoms wake you at night? [ ] Yes [ ] No

What alleviates your symptoms? (Please check all that apply)

[ ] Coughing/sneezing [ ] Moving [ ] Stress
[ ] Cold [ ] Reaching across body [ ] Sustained bending
[ ] Cutting/pivoting [ ] Reaching behind back [ ] Swallowing
[ ] Exercise [ ] Reaching in front of body [ ] Taking deep breaths
[ ] Going to/rising from sitting [ ] Recreation/sports [ ] Talking
[ ] Heat [ ] Repetitive activities [ ] Chewing
[ ] Kneeling [ ] Rest [ ] Twisting
[ ] Jumping [ ] Sitting [ ] Wearing splint/orthotics
[ ] Lying down [ ] Sleeping [ ] Uneven ground
[ ] Looking overhead [ ] Squatting [ ] Up/down stairs
[ ] Massage [ ] Standing Other: _____
[ ] Medication [ ] Stretching

What aggravates your symptoms? (Please check all that apply)

[ ] Coughing/sneezing [ ] Moving [ ] Stress
[ ] Cold [ ] Reaching across body [ ] Sustained bending
[ ] Cutting/pivoting [ ] Reaching behind back [ ] Swallowing
[ ] Exercise [ ] Reaching in front of body [ ] Taking deep breaths
[ ] Going to/rising from sitting [ ] Recreation/sports [ ] Talking
[ ] Heat [ ] Repetitive activities [ ] Chewing
[ ] Kneeling [ ] Rest [ ] Twisting
[ ] Jumping [ ] Sitting [ ] Wearing splint/orthotics
[ ] Lying down [ ] Sleeping [ ] Uneven ground
[ ] Looking overhead [ ] Squatting [ ] Up/down stairs
[ ] Massage [ ] Standing Other: _____
[ ] Medication [ ] Stretching

Medications you are currently taking: (Please check all that apply)

[ ] Antacids
[ ] Advil/Aleve
[ ] ibuprofen/naproxen
[ ] antihistamines
[ ] Decongestants
[ ] Tylenol
[ ] Aspirin
[ ] Analgesics
[ ] Steroids
[ ] Anticoagulant
[ ] Relaxants
[ ] Herbal supplements

Other: _____

Family History: (Please check all that apply)

[ ] Heart disease
[ ] Diabetes
[ ] Arthritis
[ ] Hypertension
[ ] Osteoporosis
[ ] Psychological
[ ] Stroke
[ ] Cancer

Other: _____

Personal Medical History: (Please check all that apply)

[ ] Arthritis
[ ] Blood disorder
[ ] High blood pressure
[ ] Diabetes/high blood sugar
[ ] Low blood sugar/ hydroglycemia
[ ] Head injury
[ ] Multiple sclerosis
[ ] Kidney problems
[ ] Ulcers/stomach problems
[ ] Broken bones/fractures
[ ] Circulation/vascular problems
[ ] Lung problems
[ ] Muscular dystrophy
[ ] Cancer
[ ] Thyroid problems
[ ] Infectious disease
[ ] Developmental/growth problems
[ ] Depression
[ ] Osteoporosis
[ ] Heart problems
[ ] Stroke
[ ] Parkinson disease
[ ] Seizures/epilepsy
[ ] Allergies
[ ] Repeated infections
[ ] Skin disease

Other: _____

Symptoms you have experienced in the past year: (Please check all that apply)

[ ] Chest pain
[ ] Heart palpitations
[ ] Cough
[ ] Hoarseness
[ ] Shortness of breath
[ ] Dizziness/blackouts
[ ] Coordination problems
[ ] Weakness in arms/legs
[ ] Loss of balance
[ ] Difficulty walking
[ ] Joint pain/swelling
[ ] Pain at night
[ ] Difficulty sleeping
[ ] Loss of appetite
[ ] Nausea/vomiting
[ ] Bowel problems
[ ] Weight loss/gain
[ ] Urinary problems
[ ] Fever/chills/sweats
[ ] Headaches
[ ] Hearing problems
[ ] Vision problems
[ ] Difficulty swallowing

Other: _____

Please list any recent/relevant surgeries or hospitalizations:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Do you smoke? [ ] Yes [ ] No Packs per day: _____ Cigars/pipes per day: _____

Have you smoked in the past? [ ] Yes [ ] No Year quit: _____

How many days per week do you consume alcoholic beverages? _____ How many drinks per day? _____

How often do you exercise: [ ] 5+ days/week [ ] 1-2 days per/week [ ] Occasionally [ ] Never

What do your athletic/recreational activities entail: _____

Other Providers you have seen for this problem:

[ ] Acupuncturist
[ ] Cardiologist
[ ] Chiropractor
[ ] Dentist
[ ] Family practioner
[ ] Internist
[ ] Massage therapist
[ ] Neurologist
[ ] Orthopedist
[ ] Osteopath
[ ] Pediatrician
[ ] Podiatrist
[ ] Occupational therapist
[ ] OB/GYN
[ ] Primary care physician
[ ] Rheumatologist

Other: _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC

Payment Policy and Procedures

Please read carefully before you sign. Your signature acknowledges understanding of items set forth herein. If you have questions regarding any sections, please ask our staff for assistance.

Release of Information

I give permission to OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer and/or related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment. I authorize OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC to obtain medical records and/or professional information from my physician and other medical professionals as it relates to my treatment. _____**Initials**

Consent to Medical and Therapeutic Services

I consent to the procedures, which may be performed during the duration of care at Optimum Performance Physical Therapy, LLC. I understand that if I fail to carry out the follow-up medical care, I do so at my own risk. I also understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls, and other similar injuries, and the only alternative to entirely avoid these risks would be to forego rehabilitation altogether. I understand that I have been referred for rehabilitative treatment and care to Optimum Performance Physical Therapy, LLC. Optimum Performance Physical Therapy, LLC has described my individual treatment plan. I understand that I have the right to have any questions answered prior to receiving any treatment, including any risks or alternative treatment plan that has been prescribed by my physician and or recommended by my therapist. _____**Initials**

Financial Agreement/ Guarantee of Payment and Assignment of Benefits

I request that payment of authorized insurance company(s), attorney, or legal representative, be made on my behalf to OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC. I authorize, OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, if it chooses, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, its agents, and employees are hereby released from any and all liability of any nature that may arise from the release of information. I guarantee the payment of the full and entire allowed amount of all bills for services rendered for the patient. Any self-pay amounts not paid within forty-five (45) days of any notice of non-payment shall be subject to progressive collection activities up to and including referral to an independent collection agency or attorney for legal action, plus attorney fees up to 33 1/3% additional and court costs. I also understand that all insurance coverage quoted to me and /or responsible parties are estimated, and final determination of benefits and coverage lies with my insurance company. I certify that I have disclosed all health coverage information and I agree to provide OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, with any changes in my insurance coverage in a timely manner. I understand that as a courtesy and based on the information I provide, OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, will attempt to verify my insurance benefits. I understand that verification is never a guarantee of payment. I am responsible for payment of all co-pays and coinsurance estimates at the time of service and that these estimates may be higher than those for my primary care physician. Once my insurance company has processed claims, if the amount collected at the time of service was not enough to cover my portion, I may be billed in addition to cover my portion. Likewise, if the estimate I paid was more than my portion, I may be entitled to a refund. After 90 days of billing any secondary payer, unpaid coinsurance may become my responsibility.

_____**Initials**

_____

Printed Name of Patient or Guardian

_____(seal) Date: _____

OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC

Managed Care Plan Obligations

I understand that my insurance carrier may require me to have a current and complete written referral from my primary care physician. I understand that OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, recommends I check with my carrier directly. If a referral is required and is not presented prior to my treatment being rendered, my insurance may not cover all or a portion of the medical expenses incurred. In this instance, I am responsible for all uncovered charges. It is my responsibility to assist OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC in obtaining additional referrals when necessary and appropriate. Should I require additional or more specific information regarding my insurance coverage, I will contact my carrier directly. _____**Initials**

Cancellation/No Show Policy/Late Policy

It is our desire at OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC to provide every patient with the highest quality of care and services in a timely manner. Therefore, we provide a reserved time slot for each patient so there is minimal waiting, and each patient receives individual care.

In order to continue with this high-quality service, we ask that you call at least 24 hours in advance if you are unable to keep your scheduled appointment. Missed appointments or greater than 15 minutes late without notifying staff, **may result in a $75 no show/cancellation fee**. Furthermore, additional scheduled visits may be automatically cancelled.

We understand that personal schedules can be hectic, but to accommodate the needs of all our patients, we must maintain some level of accountability. Missed appointments on your part do not allow for continuity of care and affects your ability to reach the goals set by you and your physical therapist.
Thank you for your consideration, our staff and other patients who may need your appointment time.

_____**Initials**

HIPAA Privacy Authorization

I, _____, give OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, permission to share my information with

□ Any member of my family
□ These Individuals: _____
□ Do not speak or share any of my information with family or friends, unless I give written/verbal permission

Your information may be sent to healthcare providers, health insurance companies protected by the federal privacy regulations, and to the individual(s) of your choice.

Your information may be:

- Transferred or utilized between the administration and professional staff
- Transferred from OPPT to the billing contractor who handles our billing. They have signed an agreement not to utilize your records other than those necessary to administer your insurance claim and pervade internal reports to OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC.

You may refuse to sign this authorization and it will not affect your ability to obtain treatment. You may receive a copy of this authorization at the time of signing and/or revoke this authorization at any time by sending a written notificati0on to the office _____ **Initials**.

_____ Date: _____
Printed Name of Patient or Guardian

_____(seal) _____
Signature of Patient or Guardian Date

Optimum Performance Physical Therapy, LLC
8600 LaSalle Road
Chester Bldg.; Suite 322
Towson, MD 21286

Understanding Your First Visit

Cancellation Policy

We take great pride in the *time* and *service* we provide our patients. We know your time is valuable and we are dedicated to providing you a thorough, comprehensive treatment at each and every visit. You will always be served with the highest level of respect, integrity and in the most cost-effective manner.
We would appreciate *your* consideration as well. Patient cancellations and missed appointments are inevitable. In the event you are going to be late or cannot attend your appointment, please call Optimum Performance Physical Therapy at 410-828-OPPT (6778) to notify our staff. **Failure to notify staff may result in a $75.00 cancellation/no show fee less than 24 hour notice.**

Insurance

We participate with most insurance plans. Ultimately, it is your responsibility to know and understand the terms of your insurance coverage. Your insurance plan is a contract between you and your carrier. It is your responsibility to know whether your insurance carrier requires a referral or script. In the event that you arrive without a referral when one is required, you will be responsible for the bill or your visit will be rescheduled. We will verify benefits for Physical Therapy and help you understand your coverage. Please remember however, that benefits are not a guarantee of coverage or payment.

Co-Payment: This is a fixed amount set by your insurance company, which you are obligated to pay at the time of service. If your co-pay becomes a burden, please let us know. Legally we cannot waive your co-pay, but we can offer payment plans. Our main goal is to optimize your quality of life.

Co-Insurance: This is your cost share, usually calculated as a percentage of the cost of the service. Each plan and coverage is different. Please check with your insurance company.

Deductible: This is the amount you are responsible for before your insurance plan starts paying for services. Deductibles may not apply to all services. Please check with your insurance company.

Home Exercises

During your time at Optimum Performance Physical Therapy, LLC, we will prescribe exercises to be completed at home. These are individually designed to focus on your biggest limitations. It is important to complete the exercises as prescribed to make gains in range of motion, strength, and function. Failure to comply with the exercise recommendations prescribed to you can adversely affect your recovery. Please make your home exercise program a top priority. We want the best for you and your health. Your active participation and diligence will help us help YOU!

If you have questions or concerns, contact us at 410-828-OPPT (6778) or www.oppt.biz.
We look forward to working with you!

Name: _____ Date: _____

HEADACHE DISABILITY INDEX

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: ***PLEASE READ CAREFULLY:*** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	^	^	^
F2. Because of my headaches I feel restricted in performing my routine daily activities.	^	^	^
E3. No one understands the effect my headaches have on my life.	^	^	^
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	^	^	^
E5. My headaches make me angry.	^	^	^
E6. Sometimes I feel that I am going to lose control because of my headaches	^	^	^
F7. Because of my headaches I am less likely to socialize.	^	^	^
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	^	^	^
E9. My headaches are so bad that I feel I am going to go insane.	^	^	^
E10. My outlook on the world is affected by my headaches.	^	^	^
E11. I am afraid to go outside when I feel a headache is starting.	^	^	^
E12. I feel desperate because of my headaches.	^	^	^
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	^	^	^
E14. My headaches place stress on my relationships with family or friends.	^	^	^
F15. I avoid being around people when I have a headache.	^	^	^
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	^	^	^
F17. I am unable to think clearly because of my headaches.	^	^	^
F18. I get tense (e.g. muscle tension) because of my headaches.	^	^	^
F19. I do not enjoy social gatherings because of my headaches.	^	^	^
E20. I feel irritable because of my headaches.	^	^	^
F21. I avoid traveling because of my headaches.	^	^	^
E22. My headaches make me feel confused.	^	^	^
E23. My headaches make me feel frustrated.	^	^	^
F24. I find it difficult to read because of my headaches.	^	^	^
F25. I find it difficult to focus my attention away from my headaches and on other things.	^	^	^