OPTIMUM PHYSICAL THERAPY ASSOCIATES, P.C.

Patient's Name:_____, _____ Date_____
Last First MI

Patient's Date of Birth____/_____/_____ Email_____

Phone w/area code_____work phone_____cell phone_____

Address:_____
Street City State Zip Code

Insurance Name_____

Referring Physician (if any)_____
Location at which you see Referring Physician _____

Diagnosis/ condition for therapy_____

_____

Date of next visit with Referring Physician _____

Primary Physician_____Phone Number_____
Would you like your notes sent to your primary physician? ☐ YES ☐ NO

Who should we contact in case of Emergency?_____Phone_____

If you had an accident or work-related injury please complete the box below;

Date of Accident:_____ ☐ Auto ☐ Work Related
Attorney's Name, if any_____Phone _____
Insurance Company:_____
Address_____Phone_____
Claim Number_____Adjuster_____Name of Insured_____

Please provide a copy of your insurance card(s) and complete information below on the insured's name and date of birth if different from the patient's. (Only include ID numbers if cards were not provided.)

Primary Insurance:
Insured's Name _____Birth Date_____
ID Number_____Group Number_____
Secondary Insurance _____
Insured's Name _____Birth Date_____
ID Number_____Group Number_____

Please tell us how you learned of our services or whom we may thank

☐ I was previously a patient
☐ Doctor Recommendation
☐ Insurance Company
☐ Yellow Pages Ad
☐ Webpage
☐ Former Patient Recommendation; Name_____
☐ Family or Friend Recommendation; Name_____
☐ Case Manager Recommendation
☐ Newspaper Ad
☐ Other, please specify _____

To ensure you receive a complete and thorough evaluation, please provide us with the important background information requested on this form. If you do not understand a question, please leave it blank and your therapist will assist you. Thank you!

Leisure Activities, Sports or Hobbies:_____

Employer:_____Occupation:_____

Your insurance company requires a date of onset for billing purposes. Please provide the date of onset of current condition with month/day/year. _____

Height:_____Weight:_____

Briefly state how your injury occurred: _____

Any previous Physical Therapy? ☐ Yes ☐ No
If yes briefly state why: _____

Have you recently noticed?
☐Yes ☐No Night Pain
☐Yes ☐No Weight loss/gain
☐Yes ☐No Nausea/Vomiting
☐Yes ☐No Dizziness/Lightheadedness
☐Yes ☐No Headache(s)
☐Yes ☐No Fatigue
☐Yes ☐No Weakness
☐Yes ☐No Fever/Chills/Sweats
☐Yes ☐No Numbness or Tingling

Allergies: Please list any allergies:_____
☐Yes ☐No Are you latex Sensitive?

Please check any of the following whose care you are under:
☐ Physician (MD, DO) ☐ Podiatrist (DPM) ☐ Psychiatrist/Psychologist ☐ Dentist
☐ Physical Therapist ☐ Chiropractor (DC) ☐ Other_____
If you have seen any of the above professionals during the last 3 months, please describe the reason (illness, medical, routine, etc) _____
_____

Have you EVER been diagnosed as having any of the following conditions?

☐Yes ☐No Cancer
☐Yes ☐No Cardiac Problems
☐Yes ☐No Pace maker
☐Yes ☐No High Blood Pressure
☐Yes ☐No Cholesterol
☐Yes ☐No Circulation Problems
☐Yes ☐No Asthma
☐Yes ☐No Emphysema/Bronchitis
☐Yes ☐No Chemical Dependency (alcohol/drug)
☐Yes ☐No Thyroid problems
☐Yes ☐No Diabetes Type 1☐/ Type 2☐
☐Yes ☐No Multiple sclerosis
☐Yes ☐No Autoimmune Disorder
☐Yes ☐No Other Arthritic Condition
☐Yes ☐No Depression
☐Yes ☐No Anxiety
☐Yes ☐No Hepatitis
☐Yes ☐No Tuberculosis
☐Yes ☐No Stroke
☐Yes ☐No Kidney Disease
☐Yes ☐No Anemia
☐Yes ☐No Osteoporosis/Osteopenia
☐Yes ☐No Seizures
☐Yes ☐No H.I.V.
☐Yes ☐No Spina Bifida
☐Yes ☐No Migraines
☐Yes ☐No Vision Problems
☐Yes ☐No Hearing Problems
☐Yes ☐No Fibromyalgia
☐Yes ☐No Metal Implants
☐Yes ☐No Gallbladder Problems
☐Yes ☐No Incontinence
☐Yes ☐No Parkinson's
☐Yes ☐No Speech Problems

☐Yes ☐No During the Past Month have you been feeling down, depressed or hopeless?
☐Yes ☐No During the Past Month have you been bothered by having little interest or pleasure in doing things?

☐Yes ☐No Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?

☐Yes ☐No FOR WOMEN: Are you currently pregnant or do you think you might be pregnant?

Please List any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization.

Date:	Reason for Surgery/Hospitalization:

Please describe any significant injuries for which you have been treated (including fractures, dislocations, and sprains) and the approximate injury date.

Date	Injury	Date	Injury

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

☐Yes ☐No Diabetes ☐Yes ☐No Heart Disease ☐Yes ☐No Migraines
☐Yes ☐No Cancer ☐Yes ☐No Stroke

Please complete below table, include script and over the counter meds **OR provide a list to copy.**

Current Medication(s):	Dosage & Frequency:	Route:	Reason:

How many caffeine-containing beverages do you drink per day?_____
How many packs of cigarettes do you smoke per day?_____
How many days per week do you drink alcohol?_____
If one drink equals one beer or glass of wine, how much do you during at an average sitting?_____

How many falls have you experienced in the past 12 months? _____
(Note: A fall is defined as any unintentional descent to a lower position, i.e. fall into a chair, sliding from a chair to the floor, etc.)

Are you receiving ANY home care services, including a nurse? ☐Yes ☐No

Optimum
Physical Therapy Associates, PC

Patient's name (printed)_____ Date_____

Financial Policy

Patients with insurance coverage; Optimum Physical Therapy Associates, PC ("Optimum") will help you obtain information about your physical therapy benefit from your insurance plan and will bill your insurance company. The physical therapy service you have elected to utilize results in a financial responsibility on your part. This responsibility obligates you to ensure full payment of our fees. You are responsible for payment of your bill. Optimum's review of your benefits is not a guarantee that your insurance company will pay Optimum's bills. **You are responsible for calling your insurance company and verifying the benefits of your plan**. All or portions of the bill may not be covered by your insurance company and will have to be paid by you. Usually, there is a co-payment and/or an annual deductible as determined by the insurance plan you choose.

I have read the above financial policy regarding my financial responsibility to Optimum for providing physical therapy services to me, or the above named patient. I certify that the information I have provided to Optimum is, to the best of my knowledge, true and accurate. I authorize my insurer to pay Optimum the full and entire amount of the bill incurred by me, or the above named patient, and agree to pay directly to Optimum any amount that my insurance company does not pay.

Patient/Parent/Legal Guardian Signature: _____

Optimum
Physical Therapy Associates, PC

Patient's name (printed)_____

Consent To Treatment

I have been informed by a physical therapist about the nature and purpose of my physical therapy evaluation, the procedures to be performed, and the proposed course of treatment. I have been informed of the expected benefits of the proposed treatment as well as the probability of their occurrences. I have been informed about the reasonable alternatives to the proposed treatment and the potential risks and consequences of both receiving and foregoing treatment. I acknowledge that there are no guarantees or assurances, and none have been made to me, that physical therapy treatment will help any condition or that I will achieve a specific result. I have had the opportunity to ask and have answered any questions that I have regarding my evaluation and the proposed course of treatment. I understand that I have the right to refuse any treatment at any time for any reason. My signature on this form indicates that I knowingly and voluntarily consent to treatment and understand the risks, benefits, and treatment program as they have been explained to me.

Patient Signature_____ Date_____

The above named patient is a minor or otherwise unable to consent on his or her behalf. I represent that I am the parent or legal guardian of the above named patient and have the legal authority to consent to his or her evaluation and treatment.

Parent/Legal Guardian _____ Date_____

No Show/Cancellation Policy

Your therapist reserves specific time for your appointment. We understand that there may be times when you must cancel an appointment, but we require a minimum of 24 hours notice of any cancellation. Any missed or canceled appointment with less than a 24 hour notice may result in a charge of $25.00 that is not billable to your insurance and for which you are personally responsible.

Patient/Parent/Legal Guardian Signature _____ Date_____

OPTIMUM PHYSICAL THERAPY ASSOCIATES, P.C.
727 S. CHESTER ROAD, SWARTHMORE, PA 19081
133 TURNER LANE, WEST CHESTER, PA 19380
708 W NIELDS STREET, WEST CHESTER, PA 19382

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Optimum Physical Therapy Associates, P.C. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:

OPTIMUM PHYSICAL THERAPY ASSOCIATES, P.C.
727 S. CHESTER ROAD
SWARTHMORE, PA 19081
Attention: Practice Compliance Director

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.
I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): ____

_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable _____Other Explain)_____

_____
Signature of Authorized Practice Representative

OPTIMUM PHYSICAL THERAPY ASSOCIATES, P.C.
719 S. CHESTER ROAD SWARTHMORE, PA 19081
133 TURNER LANE, WEST CHESTER PA 19380
708 W NIELDS ST, WEST CHESTER, PA 19382

NOTICE OF PROTECTED HEALTH INFORMATION 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.

Purpose of Notice

Under the federal healthcare privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Optimum Physical Therapy Associates, P.C. ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. Uses and Disclosures with Patient Consent: Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

    a. Treatment. We are permitted to use your health information in the provision and coordination of your healthcare. We may disclose information contained in your medical record to your primary healthcare provider, consulting providers, and to other healthcare personnel who have a need for such information for your care and treatment. For example, your physical therapist may disclose your health information when consulting with a physician regarding your medical condition.

    b. Payment. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies or portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

    c. Healthcare Operations. We are permitted to use and disclose your health information during the Practice's routine healthcare operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. Uses and Disclosures With Patient Authorization. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or healthcare operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. Uses and Disclosures With Patient Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object. Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

    a. Uses and Disclosures Required by Law. We will disclose your health information when required to do so by law.

    b. Public Health Activities. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

    c. Abuse and Neglect. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

    d. Regulatory Agencies. We may disclose your health information to a healthcare oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the healthcare system, government programs and compliance with civil rights.

    e. Judicial and Administrative Proceedings. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

    f. Law Enforcement Purposes. We may disclose your health information to law enforcement officials when required to do so by law.

    g. Coroners, Medical Examiners, Funeral Directors. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

    h. Research. Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

i. Threats to Health and Safety. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. Military/Veterans. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. Workers' Compensation. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. Marketing. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face, concerns products or services of nominal value, or identifies us as the communicating party and that we will receive remuneration for making the communication and, where required by the Privacy Regulations, instructions describing how you may verbally object to receiving future communications.

m. Appointment Reminders. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. Other Uses and Disclosures. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. Uses and Disclosures to Business Associates. With an acknowledgement or a proper authorization, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. Right to Request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and healthcare operations. However, we are not required to agree with such a request. If, however, we agree to the requested restriction, it is binding on us.

2. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. Right to Verbally Object. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. Right to Seek an Amendment of Your Health Information. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. Right to an Accounting of Disclosure of Your Health information. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request; provided, however that we need not provide an accounting for any information disclosed prior to April 14, 2003. The accounting will not include disclosures related to treatment, payment or healthcare operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations, disclosures to persons involved in your care, or disclosures that occurred prior to the April 14, 2003 compliance deadline under the Privacy Regulations. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. Right to Confidential Communications. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. Right to Revoke Your Authorization. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

8. Right to Receive Copy of this Notice. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at (610) 565-1671. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact the Compliance Officer at (610)565-1671. All complaints must be submitted to the Practice in writing at 719 S. Chester Road, Swarthmore, PA 19081. There will be no retaliation for filing a complaint.

Effective Date

The effective date of this Notice is ___2/12/2007.