1027 Regents Blvd. Fircrest, WA 98466 Phone: (253) 301-3783 Fax: (253) 301-3254

Patient Information

Name_____ ☐ Male ☐ Female
First *Middle* *Last*

Date of Birth____/____/____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____
Street Address City State Zip

Email Address_____
By providing your email address below, you agree to receive email appointment reminders.

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____
Appointment reminders ☐ Yes, notify me by text or ☐ No, do not notify me by text

Employer:_____ Occupation:_____
(REQUIRED FOR WORKER COMPENSATION CASES)

Emergency Contact:_____ Phone: (_____) _____-_____Relation:_____

How did you hear about us?_____

Optimum Physical Therapy (OPT) Policies Insurance/Billing Information

Please Provide Optimum Physical Therapy with your Primary and Secondary health insurance information and a copy of your insurance card(s).

PRIMARY INSURANCE

Name of Subscriber:_____ _____Date of Birth____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insurance Co:_____ Phone: (_____) _____-_____

Subscriber #:_____Group#/Name:_____

Subscriber's Address:_____ Phone: (_____) _____-_____

SECONDARY INSURANCE

Name of Subscriber:_____ _____Date of Birth____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insurance Co:_____ Phone: (_____) _____-_____

Subscriber #:_____Group#/Name:_____

Subscriber's Address:_____ Phone: (_____) _____-_____

WORKER'S COMPENSATION CARRIER

Carrier:_____Claim #_____

Adjuster's Name:_____ __ Ph: (_____) _____-_____

Please complete reverse side

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Optimum Physical Therapy (OPT) Policies

Carefully read the following information. If you have any questions, please discuss them with us.

Payment Policy: As a courtesy, Optimum Physical Therapy (OPT) has verified your insurance benefits and we will bill your primary insurance carrier for you. Please remember that you are ultimately responsible for payment of all services rendered. Your portion of payment: Private pay, co-payment, co-insurance and/or deductible payments are required at time of service for each visit. I certify the information supplied on this form is true to the best of my knowledge. I will notify Optimum Physical Therapy of any changes in the listed information. I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand and agree that if it becomes necessary to commence legal actions for the collection of outstanding charges on my account. I will be responsible for any costs and/or court fees in addition to the outstanding balance.

I hereby authorize Optimum Physical to furnish my insurance carrier(s) any and all requested information concerning my health. I also authorize my insurance carrier(s) to pay Optimum Physical Therapy directly for any services rendered. I have read the above policy and I acknowledge that I am ultimately responsible for payment of all services rendered.

Signature: _____ Date: _____/_____/_____
(Patient or Legal Guardian)

Privacy Policy:
I have received/reviewed a copy of OPT's Health Insurance Privacy Policy. _____(initial).
(POSTED AT RECEPTION DESK, COPY AVAILABLE UPON REQUEST)

Cancellation Policy: I understand that physical therapy is an on-going process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or accept an abbreviated treatment for the day. I also understand that failure to give 24 hour advanced notice of cancellation may result in a $25 fee _____***(initial)***.

Authorization of Release of Specific Information

Initial all statements that apply:

_____I authorize you to leave messages regarding my appointments on my answering machine or voicemail as listed on my patient information.

_____I authorize you to discuss my appointments with my spouse/partner_____.

_____In addition to my referring doctor, I authorize you to communicate with and send reports and evaluations to the following:

_____

Medical Questionnaire

Please fill out the following form as completely as possible. This will allow your therapist to safely and accurately diagnose your condition and develop a plan of care specific to your needs. Your therapist will review this form with you during your evaluation.

Last Name: _____ **First Name**: _____ **M.I**. ____ **Age**:_____

Height:_____ Weight:_____ Occupation:_____ Sex: ___Male ___Female

CASE HISTORY: Referring Physician:_____Diagnosis:_____

Date of injury/symptom onset: _____ Briefly describe onset:_____

_____

Surgery: Yes ___ No___ Date of surgery:_____ Surgery performed:_____

Diagnostic testing: None:___ X-ray:___ MRI: ___ Bone Scan: __ CT Scan: ___ EMG/NCV: __ Other: _____

Current complaints: Difficulty walking: ___ Pain: ____ Stiffness/tightness: ____ Numbness: ___ Tingling: ____

Imbalance: ____ Weakness: ____ Loss of function: ____ Other:_____

Prior history of symptoms/treatment: _____

Physical Therapy: ___ Occupational Therapy: __ Chiropractic: __ Massage: ___ Pain Clinic: __ Other _____

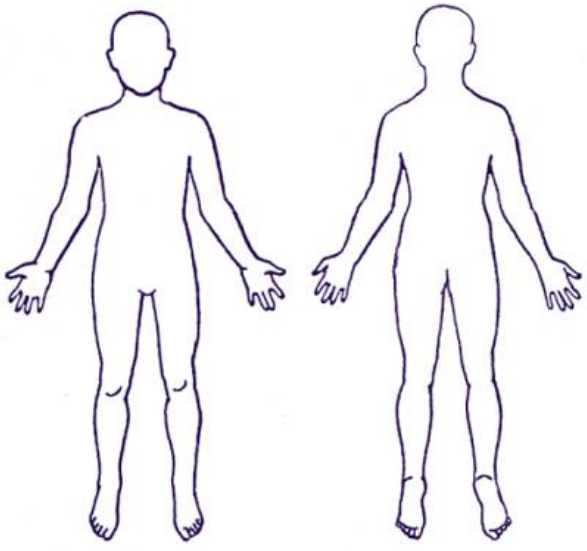
Pain Frequency: Constant/Unrelenting: ___ Comes and goes: ___ Occasional (less than daily):____ Sporadic: _____

Pain Quality: Aching: ____ Burning: ___ Dull: ___ Sharp: ___ Stabbing/Shooting: ___ Sore: ___ Throbbing: ___

Aggravating factors/activities:_____

Easing factors/activities:_____

Indicate region(s) of pain on the diagram below:



Pain Rating (on scale from 0-10, 0=none 10=worst imaginable):

Now . . . . . ____

At worst. . . . . ____

At best. . . . . ____

With rest/meds ____

Please place a mark on the line below indicating you average pain

No pain Worst Pain

List **MEDICATIONS** (or provide a list) you are **currently**, or have **recently** taken**:**

NAME	DOSAGE	FREQUENCY	ROUTE

I CURRENTLY HAVE, OR HAVE HISTORY OF: (Check all that apply)

___ Coronary artery disease ___ Headaches ___ Frequent falls ___ Numbness around lips

___ High Blood Pressure ___ Epilepsy/Seizures ___ Thyroid problems ___ Vertigo

___ Heart Trouble/Angina ___ Shortness of breath ___ Diabetes ___ Dizziness

___ Poor circulation ___ Asthma ___ Osteoporosis ___ Hearing problems

___ Pacemaker/Nitroglycerin ___ Allergies ___ Osteoarthritis ___ Double vision

___ bruising easily ___ Smoking/tobacco ___ Rheumatoid Arth. ___ Unrelenting night pain

___ Fever/chills/night sweats ___ Unexplained weight gain/loss (>10 lbs) ___ Recent infection

___ Bladder dysfunction ___ Transplant/IV drug/long term steroid use ___ Saddle region numb/tingling

___ Weakness/numbness/tingling in both arms/legs ___ Unexplained fall w/out loss of balance/consciousness

___ Cancer history (Type/status): _____

___ Prior Surgeries or Other: _____

All Patients: Over the last two weeks have you had thoughts of suicide? ___ Yes ___ No

Females: I have had a pelvic exam (PAP) within the last 12 months ___ Yes ___ No

I have had a mammogram or breast exam within the last 12 months ___ Yes ___ No

I am or may be PREGNANT ___ Yes ___ No

Males: I have had a prostate exam within the last 12 months. ___ Yes ___ No

GOALS for Physical Therapy: _____

I give consent to Optimum Physical Therapy to provide physical therapy services to me, my child or my legal ward. I attest the above information provided is accurate to the best of my knowledge.

Signature: _____ Date: _____/_____/_____

(Patient or Legal Guardian)

OPTIMUM PHYSICAL THERAPY, LLC. NOTICE OF PRIVACY 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.

OUR COMMITMENT TO PROTECT YOUR MEDICAL AND PERSONAL INFORMATION

Optimum Physical Therapy, LLC (OPT) is committed to protecting the privacy of your medical record and personal information. This includes information OPT receives about your past, present or future health condition, previous healthcare you have received and/ or payment for this healthcare. OPT is required by law to protect the privacy of your health information and to provide this notice that explains how, when and why OPT uses or disclose medical information about you. Your medical record and personal information will not be disclosed in any way to a third party except as described in this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION WITHOUT AUTHORIZATION

Exception Group I: Treatment, Payment or Health Care Operations

For Treatment: OPT can disclose medical information about you to nurses, doctors, medical assistants, physical therapy students and other healthcare personnel who provide you with healthcare services or are involved with your care.

For Payment: OPT can disclose medical information about you in order to bill and collect payment for the treatment and services OPT provided you. OPT may be required to furnish your insurance carrier company with detailed records of the services OPT has provided, for them to pay for your care. OPT may also contact your insurance company to obtain prior authorization and approval of treatments you are about to receive to ensure they are covered by your plan.

OPT may be required to disclose medical information to third party "business associates" including billing and claims processing companies and any other service that provides assistance with healthcare claims. OPT strictly requires these associate businesses to also protect your medical record and personal information.

For Heath Care Operations: OPT can disclose medical information about you to perform facility operations that support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical and physical therapy students, and conducting or arranging for other business activities. OPT may contact you to provide appointment reminders, perform follow-up interviews, or provide information about treatment alternatives or health-related benefits or services that might interest you. OPT may provide medical information to third party "business associates" including: billing company, transcription, attorneys, consultants, and others to ensure OPT are complying within the laws that affect us. OPT strictly requires these associate businesses to also protect your medical record and personal information.

Exception Group II: Public Health Activities

For Collection of Information by Public Health Agencies: OPT can disclose medical information about you to a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury or disability. This information may be used to report disease, injury or vital events and to conduct public health surveillance, public

health investigations and interventions. OPT may also disclose medical information to a foreign government agency that is collaborating with a public health agency.

For Health Oversight Activities: OPT may disclose medical information about you to a health oversight agency for activities authorized by law. These oversight activities include: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

For Child Abuse or Neglect: OPT can disclose medical information about you to a government authority by law to receive reports of child abuse or neglect.

To Avert a Serious Threat to Health and Safety: OPT can disclose medical information about you to prevent a serious threat to your health and safety, or to the health and safety of the public or another person. The medical information would only be disclosed to a person or group able to help prevent the threat or lessen such harm.

Exception Group III: Other Permitted Disclosures (Without Authorization)

If Required By Law: OPT can disclose medical information about you to the extent that the Federal, State or Local law requires. For example, OPT will make medical information disclosures to government agencies and law enforcement agencies regarding victims of abuse, neglect, domestic abuse, when dealing with gunshot wounds, report reactions to medications, or problems with products, or to notify people of recalls of products they may be using.

For Legal Proceedings: OPT can disclose medical information about you in response to a court or administrative order if you are involved in a lawsuit or dispute. OPT may also disclose medical information in response to a court or administrative ordered subpoena or discovery request, but only after efforts have been made to inform you in regards to the order.

For Minors: OPT can disclose medical information about minors to their parents or legal guardians. However, in instances where California law allows minors to consent to their own treatment, information will not be released to their parents with the minor's consent.

For Individuals Involved in your Care/Disaster Relief Agencies: OPT can disclose medical information about you to a family member, friend, or other person who is involved in your care or payment for your health care. OPT may disclose medical information to disaster relief agencies so that your family can be notified about your condition status or location. **You have the right during registration to restrict what information is provided and to whom.**

For Worker's Compensation: OPT is authorized by law to disclose medical information about you in certain situations relating to reporting workplace injuries. OPT may also disclose medical information about you to determine if you are eligible for benefits for work-related injuries or illnesses.

For Military or Veterans: OPT can disclose medical information about members of the Armed Forces to military command authorities. OPT may also release information about foreign military personnel to foreign military agencies. OPT may also disclose medical information to the Department of Veterans Affairs upon discharge from military services. This disclosure may be necessary to determine if you are eligible for certain benefits.

For Employers: OPT can disclose medical information about you to your employer if health care services are provided to either: 1) conduct an assessment relating to the medical examination for your workplace or, 2) to determine the extent of your work related injury or illness. Any other disclosure will only be made with a signed authorization release for that information.

For National Security and Intelligence: OPT can disclose medical information about you for national security purposes, such as protecting the President of the United States or foreign dignitaries, or for conducting intelligence operations.

For Research: In some instances, OPT can disclose medical information about you for research. All research projects which require medical records are subject to a special approval process which will evaluate the precautions used to protect you and your medical records. In most cases, information which identifies you will be removed.

USES AND DISCLOSURES OF HEALTH INFORMATION REQUIRING AUTHORIZATION

Other Uses and Disclosures of Medical Information: Other uses and disclosure of medical information not covered in this Notice, or by the laws to pertain to our industry, will be made ONLY with written permission. If you provide us with written permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, OPT will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, OPT cannot take back any disclosure OPT had already made prior to your revocation of authorization.

HIV/AIDS Information: Use and disclosure of any medical information regarding HIV testing, HIV status, or AIDS, is protected by Federal and State law. Generally, an authorization must be obtained for the disclosure of such information, however, State law may allow for disclosure of information for public health purposes.

YOUR MEDICAL INFORMATION RIGHTS

You have the following rights regarding the medical information OPT maintains about you.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but may limit some mental health information.

To inspect and copy medical information you must submit your request in writing to Optimum Physical Therapy at 1027 Regents Blvd, Fircrest, WA, 98466. OPT shall have 48 hours from the date of receipt of your request to prepare and copy your medical records. OPT may charge a fee of $45.00 for copying.

Right to Request Restrictions: You have the right to request, in writing, a restriction or limitation on the medical information we use or disclose about you for treatment, payment or other health care operation except when specifically authorized by you, in emergency circumstances, or when required by law. You can also request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend.

OPT May Deny Your Request: Optimum Physical Therapy will consider all such requests on a case by case basis, but OPT is not legally required to accept them. If we agree to your request, we will comply with it unless the information is needed to provide you emergency treatment or by law.

Right to Amend: You have the right to request that we correct any inaccurate or incomplete information in your records. You must make your request in writing and submit it to the above address. You must include a reason that supports your request. OPT may deny your request for amendment if the record was not created by us, it is not part of the medical record kept by OPT, It is not part of the medical information you would be permitted to see or if it is complete and accurate.

Right to Request an Account of Disclosures: You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. This request must be submitted in writing and requires you state a time period that cannot exceed 6 years. The first list request within a 12 month period will be free-of-charge. For additional list requests there will be a fee for preparation.

Right to Request Confidential Communications: You have the right to request we communicate with you about medical matters in a certain way or at a certain location. For example you can request we only contact you at work or by mail. This request must be made in writing to the above address. We will accommodate all reasonable requests.

Right to Obtain a Paper Copy of this Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a paper copy of this notice, please contact the person listed below.

CONCERNS AND COMPLAINTS

If you are concerned that Optimum Physical Therapy, LLC may have violated your rights with respect to your medical information, you may file a written complaint with the person listed below. You may also send a complaint to the US Department of Health and Human Services within 180 days of the alleged violation of your rights. You will not be penalized for filing a complaint about your privacy practices. For further information regarding Optimum Physical Therapy's health information practices or if you have a complaint, please contact the following person:

Optimum Physical Therapy, LLC
ATTN: Administrative Director
1027 Regents Blvd
Fircrest WA, 98466
Phone: 253.301.3783 Fax: 253.301.3254

CHANGES

OPT reserves the right to change the terms of this Notice and our privacy policies at any time. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

Effective Date: 11/01/10