MEDICAL HISTORY FORM

PATIENT NAME: ______________________________ **DATE OF BIRTH** ____________

REFERRING PHYSICIAN'S NAME: ____________________ **DATE OF INJURY/ONSET:** ____________

PRIMARY CARE PHYSICIAN'S NAME: ________________ **ARE YOU PRESENTLY WORKING? YES NO**

CAUSE OF INJURY OR ONSET: ________________ **DATE OF NEXT MD APPT:** ________________

WHAT IS YOUR REASON FOR ATTENDING THERAPY: ______________________________

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1.____

2.____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one)

YES/NO WHAT WAS DONE? ____________ **WHAT WERE THE RESULTS?** ________________

ARE YOU ALLERGIC TO LATEX? (Circle one) YES NO If yes what is the Reaction________________

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? Yes No

IF YES, WHAT SYMPTOMS: ____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (Check all that apply)

□ ANEMIA □ DIABETES □controlled □uncontrolled □ RESPIRATORY PROBLEMS

□ ARTHRITIS □ DEPRESSION □ ASTHMA □ controlled □ uncontrolled

□ CANCER □ DIZZINESS/FAINTING □ COPD □ controlled □ uncontrolled

□ CARDIOVASCULAR PROBLEMS □ FRACTURES □ HOLTER MONITOR - currently wearing?

□ HEADACHES □ SEIZURES □ controlled □ uncontrolled □ PACEMAKER

□ HEPATITIS/HIV □ THYROID PROBLEMS □ KIDNEY PROBLEMS

□ HIGH BLOOD PRESSURE □ controlled □ uncontrolled □ LOW BLOOD PRESSURE

□ MRSA (Methicillin Resistant Staphylococcus Aureus) □ CURRENTLY PREGNANT □ OSTEOPOROSIS

If checked any above, explain: ____

□ ANY OTHER MEDICAL PROBLEMS: ____

CURRENT MEDICATIONS: ____

____

ALLERGIES: Medication ___________Reaction_____________ Other ______ Reaction________

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR/INS YEAR? YES / NO HOW MANY_____________

HAVE YOU HAD PRIOR CHIROPRACTOR SERVICE THIS CALENDAR/INS YEAR. YES / NO HOW MANY______

WAS IT RECEIVED AT: (circle one) HOSPITAL OUTPATIENT CENTER HOME HEALTH HOW MANY______

Current Pain Level: NO PAIN 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

PATIENT: ____ Date_________________________

REVIEWED BY THERAPIST(S): ________________________________ Date_________________________

Cancellation No Show Policy

At Optimal Physical Therapy, our goal is to make our clinic accessible to as many patients as possible. Because our services are in high demand, we maintain a full schedule. This allows us to provide each patient with the individual attention necessary for the highest quality care.

When a patient cancels shortly before an appointment or is a "no-show," we miss the opportunity to treat another patient. We appreciate your courtesy in calling us as soon as possible if you must cancel your scheduled appointment. Your time slot then has a better chance of being reassigned to another patient.

In the event you do not notify us within 24 hours of your appointment time to cancel your appointment you will be charged $50.00. This charge is not billed to your insurance company and you will be responsible for the Cancellation Fee.

Exceptions:
We understand those emergencies or other circumstances beyond your control that may require you to be late or miss an appointment. If so, please let us know as soon as possible. We may consider exceptions on a case-by-case basis. We appreciate your understanding and cooperation.

Discharge:
If you have 3 cancellations or no-shows and are non-compliant you may be discharged from our care. If you are feeling better and are not in need of Physical Therapy, please let us know so we can forward a note to your physician or surgeon.

Patient Name ________________________________ Date______________________

PATIENT INTAKE AND CONSENT FORM

Patient Name______________________________ **DOB:** ___________________ **Today's Date**_____________________

CONSENT TO TREATMENT I consent to rehabilitation and related services at: Optimal Physical Therapy and Wellness In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials: ____________
TREATMENT OF MINORS I, as a parent/guardian of (a minor) Name: ____ receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials: ____________
LIABILITY I know and agree that: Optimal Physical Therapy and Wellness is not responsible for loss or damage to personal valuables. Initials: _____________
WAIVER AND RELEASE I hereby release, discharge, and acquit: Optimal Physical Therapy and Wellness, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials: ____________
AUTHORIZATION OF PAYMENT I hereby assign all benefits directly to: Optimal Physical Therapy and Wellness I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice of Privacy Practices. Initial: _____________

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:
- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.

- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. Initial: _______________

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. Initials: ________________

I acknowledge receipt of the Statement of Patient Rights. Initials: ________________

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: ____ Date ____________________

Witness Signature: ____ Date ____________________

DISCLOSURE OF MEDICAL RECORDS: I authorize the following individuals to have access to my medical and billing records:

______________________________	______________________________
Name	Relationship
______________________________	______________________________
Name	Relationship
______________________________	______________________________
Signature of Patient	Date

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Markcting Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad – Facebook, Yelp, Google
- ☐ Marketing Ad - Other________________

Specify if other: ________________________________