PATIENT INFORMATION FORM

Patient Information

Patient Name			Appt. Date	
Address	City		State	Zip
Home Phone	Cell Phone		Email	
Date of Birth	SSN	Gender: M F	Marital Status: M S D W	
Emergency Contact:	Phone #		Relationship	

Employer Information

Employer Name	Employement Status: FT PT Self-Employed Retired Student		
Employer Address	City	State	Zip
Work Number	Occupation		

Referring Physician Information

Name of Physician	NPI	Phone #
Script Date	Frequency and Duration	DX / Body Part

Insurance Information

Primary Insurance	Policy#	Group #
Secondary Insurance	Policy#	Group #

Additional Information

Workers Comp	Date of Injury	WC Claim #
Auto Insurance	Date of Injury	Claim #
Insurance Adjuster	Phone #	Fax #
Case Manager	Phone #	Fax #

Insurance Policy Holder Information

Name		Contact #	Gender: M F
Address	City	State	Zip
Date of Birth	SSN #	Relationship to Patient	
Employer Name		Employer Phone #	

Patient Signature

Date

CONSENT FOR TREATMENT
RELEASE OF INFORMATION
HIPPA PRIVACY NOTICE
FINANCIAL AGREEMENT

Patient Name: ______________________________ **Date:** ______________

CONSENT: I do hereby agree and give my consent for **Optimal Physical Therapy** to furnish Therapy Treatment. ______(Please initial)

Optimal PT Solutions has my permission to allow students to observe my treatment and care. Yes _____ NO _____(check yes or no)

RELEASE OF INFORMATION: I agree that **Optimal Physical Therapy** may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medial records, to any third party payers, including , but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS YOUR PHI and/or BILLING INFORMATION.

Name: ______________________________ Relationship ______________ PHI _____ Billing _____

Name: ______________________________ Relationship ______________ PHI _____ Billing _____

HIPAA PRIVACY NOTICE: I acknowledge that I have received the HIPAA Privacy Notice and have had the opportunity to review its content. ______________ (Please initial)

FINANCIAL POLICY STATEMENT: As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payments at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Optimal Physical Therapy.**

The above does not apply for those patients that are considered Workers' Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

*****ARE YOU BEING TREATED AS A RESULT OF AN AUTO ACCIDENT: YES _____ NO_____
(If yes, have you supplied ______________ ***with your claim information?)***

*****ARE YOU BEING TREATED AS A RESULT OF A WC ACCIDENT: YES _____ NO _____
(If yes, have you supplied ____________ ***with your claim information?)***

*****ARE YOU BEING TREATED AS A RESULT OF AN ACCIDENT OF ANY KIND: YES _____ NO _____

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

______________________________ ______________

Patient/Guardian/Responsible Party **Date**

______________________________ ______________

Optimal Physical Therapy/Witness **Date**

Cancellation/No Show Policy

Successful rehabilitation is dependent upon the patient and the therapist both attending scheduled and prescribed physical therapy appointments.

We understand that emergencies and schedule conflicts will happen. Your cooperation in giving us advanced notice gives us the opportunity to allow other patients to come in for therapy and/or allow for a new evaluation at your appointment time.

If for any reason, you cannot make your appointment, please give us advance notice. ***We ask that at least 24 hour notice be given when possible. If you do not show for an appointment or do not call within 24 hours to cancel, a fee of $25.00 will be charged to you at our discretion. Any late arrival more than 15 minutes may result in a cancellation of your appointment.***

It is also our policy to discharge patients that cancel or do not show for ***three*** appointments without sufficient reason or justification. When this occurs, your remaining appointments will be cancelled and will notify your referring physician and/or worker's compensation case manager.

Thank you for choosing Optimal Physical Therapy Solutions for your therapy needs.

Please sign below to indicate that you have read and understand our Cancellation/No Show Policy.

Patient/Guardian Signature: ____

Printed Name: ____