OPTIMAL PHYSICAL THERAPY

129 W. Lake Mead Parkway, Suite 2, Henderson, NV 89015
1358 Paseo Verde Parkway, Suite 200, Henderson, NV 89012
1525 E. Windmill Lane, Suite 102, Las Vegas, NV 89123
1341 S. Rainbow Blvd, Suite 200, Las Vegas, NV 89146
5575 S. Durango Dr., Suite 111, Las Vegas, NV 89113
P: (702) 564-6712 | F: (702) 564-4838
Email: info@optimalptlv.com Website: Optimalptlv.com

PATIENT INFORMATION

Date:_____ Referring Physician: _____
Patient Last Name:_____ Patient First Name:_____ M. I.:____
Gender: Male / Female Date of Birth:_____ SS#:_____-_____-_____
Address:_____
City:_____ State: _____ Zip:_____
Email:_____ Cell: (____)_____ Home:(___)_____
Employer/School:_____
Employer/School Phone:_____ Occupation:_____
If Minor, Guardian's Name: _____
Person Responsible For Account: _____

IN CASE OF EMERGENCY:

Emergency Contact:_____ Phone:_____
Relationship to Patient:_____

HEALTH INSURANCE INFORMATION:

Primary Insurance: _____
Member ID#:_____ Group #:_____
Subscriber Name:_____ SS#:_____
Subscriber Date of Birth:_____ Relationship:_____

Secondary Insurance:_____
Member ID#:_____ Group #:_____
Subscriber Name:_____ SS#:_____
Subscriber Date of Birth:_____ Relationship:_____

Date of Injury or Onset of Symptoms: _____
Area(s) of Injury: _____ Left/Right (circle)
Have you had surgery relating to this injury? Yes / No Date of Surgery:_____

*****If yes to any of the following see receptionist for alternate paperwork*****
Is this a work-related injury? Yes / No Is this an auto accident injury? Yes / No
Do you have an attorney or seeking an attorney representation regarding this injury? Yes / No

OPTIMAL PHYSICAL THERAPY WILL NOT USE OR DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT THE CONSENT OR AUTHORIZATION OF ITS PATIENTS FOR PURPOSES OTHER THAN TREATMENT, BILLING, OR OPERATIONS RELATED TO TREATMENT AND BILLING.

Please read the following carefully, the sign and return to receptionist:
I give consent for treatment and I authorize the release of any medical information necessary to process this claim. I also request payment of any benefits to be made to OPTIMAL PHYSICAL THERAPY for this claim. I understand that I am financially responsible for all charges made to my account whether any insurance carrier, attorney, or third party payer is involved with payment. **I understand that co-pays and/or co-insurance payments are due at the time of treatment or visit. I also understand that my deductible amount must also be satisfied.**

I understand if my account becomes 30 days delinquent, a five percent (5%) finance charge will be added to my unpaid balance 30 days after my final treatment. I also understand a delinquent account may be assigned to a third party collection agency and be subject to legal process. Upon assignment, additional fees incurred (35-50%) for such services as noted above, including finance charges, will become my full responsibility, and I accept these conditions.

_____ _____

Patient Signature/Guardian **Date**

Patient Name (print):_____

INSURANCE AND TREAMENT INFORMATION

Thank you for choosing Optimal Physical Therapy as your physical therapy provider. We committed to providing you with the best care possible to facilitate your successful recovery. Please understand that payment of your bill is considered a part of your treatment commitment. The following is a statement of our financial policy. We require that you sign it prior to any treatment.

INSURANCE: Payment, deductible, and co-insurance or co-pays are YOUR responsibility and are due upon service rendered. We will, as a courtesy to you file claims to your insurance company, but payment for treatment is your responsibility whether your insurance carrier pays. Please be sure to provide us with complete insurance information. It is recommended that you contact your insurance carrier to verify your own benefits so that you are aware of your contract limitations.

MEDICARE: We accept Medicare Assignment with the following considerations: Medicare has an annual deductible at the first of each year which is your responsibility. After your annual deductible is met, you are responsible for a share of the Medicare approved amount for covered services. This share is your co-insurance due at the time of service. If you have secondary insurance, please provide us with complete insurance information. We will bill it upon request. Please be advised that there is a dollar amount limit for a Medicare patient. We need to know if you have had any physical therapy of any kind during this calendar year. This includes home health care.

WORKERS COMPENSATION: We will accept assignment for industrial insurance for work sustained injuries. If your claim is denied, YOU are responsible for payment. Therefore, check with your employer and/or insurance representative regarding the status of your claim, verifying that all forms have been completed and submitted correctly. It is vital that you keep your regularly scheduled appointments. We

must notify your physician and your workers compensation provider of any cancellations or missed appointments.

OPTIMAL PHYSICAL THERAPY CANCELLATION OR MISSED APPOINTMENT POLICY

Once your therapy program has been established, it is vital that you keep all regularly scheduled appointments to benefit the most from your program. Any appointment cancelled with less than 24 hours' notice, including "no call-no shows", will be billed as a missed appointment. This missed appointment fee of $25.00 must be paid prior to / or at the time of your next appointment. This amount is not eligible for insurance billing and is the responsibility of the patient. Please help us serve you and others by being on time for your scheduled appointments. By showing up on time and keeping your scheduled appointments we can make sure that you receive the help and attention that you deserve.

Thank you for your understanding and consideration,

Optimal Physical Therapy Team

I HAVE READ AND UNDERSTAND THE ABOVE DESCRIBED MISSED APPOINTMENT POLICY. I WILL BE RESPONSIBLE FOR ALL APPOINTMENTS NOT CANCELLED WITH 24 HOURS NOTICE, INCLUDING NO CALL-NO SHOW APPOINTMENTS. THIS WILL RESULT IN A $25.00 FEE NOT BILLABLE TO MY INSURANCE, WHICH MUST BE PAID ON OR BEFORE MY NEXT APPOINTMENT DATE.

_____ _____

Patient Signature/Guardian **Date**

Patient Name (print):_____

MINOR PATIENTS: The patient/guardian of a minor patient is responsible for payment. We require that a parent/guardian remain in the office at the time the minor is treated.

OUT OF POCKET CHARGES: In addition to co-insurance, co-pays and deductibles, certain products/supplies are used during treatment that may not be covered by insurance. We require that these supplies be paid at the time of service.

If you do not wish to pay for the above out of pocket charges, you can discuss this with your therapist and decline having the supplies/procedures used in your treatment.

I have read the financial and treatment policy above. I understand and agree to the terms.

_____ _____

Patient Signature/Guardian **Date**

Patient Name (print):_____

INFORMED CONSENT TO PHYSICAL THERAPY CARE

I hereby request and consent to the performance of Physical Therapy and other Physical Therapy procedures, including various modes of physiotherapy on myself (or on patient named below, for whom I am legally responsible) by the Doctor of Physical Therapy.

I have had the opportunity to discuss with the Doctor and/or with other office or clinic personnel, the purpose and benefits of the Physical Therapy modalities and other treatments outlined below. Various medical procedures will be reviewed and a referral will be provided if deemed medically necessary.

Though Physical Therapy and Physical Therapy treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to: fractures, disc injuries, strokes, bruising, dislocations, and sprains. I understand that I may be receiving the following treatment:

HOT/COLD THERAPY, MINERAL ICE, ULTRASOUND, EMS, MANUAL/FLEXION TRACTION, TRIGGER POINT THERAPY, VIBRATORY/DEEP TISSUE MASSAGE, TENS, THERAPEUTIC EXERCISES, LIFESTYLE AND ERGONOMIC INSTRUCTIONS, SPINAL MANULAPTION, JOINT MOBILATION TECHNIQUES, POSTURAL CORRECTION, AND DRY NEEDLING.

Patient Name (print):_____

Signature of Patient:_____**Date:**_____

Parent/Guardian Name (print):_____

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

*****Required if the patient is a minor or an adult who is unable to sign this form*****

Relationship to Patient: _____

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred by in order to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensations: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization**,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with is and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Office.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____

Patient Signature/Guardian **Date**

Patient Name (print):_____