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: _____

Gender: Male / Female Date of Birth:_____ SS#:_____

Address:_____

City/State/Zip:_____ Cell #: (_____) _____

Email:_____ Home #: (_____) _____

Employer/School:_____

Employer/School Phone:_____ Occupation:_____

If Minor, Guardian's Name: _____

DATE OF INJURY: _____

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:_____

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

PERSONAL INJURY INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ **DATE OF INJURY**: _____

****PLEASE PROVIDE INFORMATION BELOW WHICH APPLIES TO YOUR PERSONAL INJURY****

What Law Firm Represents you?_____
Address:_____ City/State/Zip:_____
Your Lawyers Name:_____ Phone:_____

Workers Comp Company:_____ Date of Injury:_____ Adjuster:_____
Employer:_____ Claim # :_____ Adjuster Phone:_____

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.

Your Car Insurance Company:_____
Address:_____ City/State/Zip:_____
Adjuster:_____ Phone:_____
Policy #:_____ Claim#:_____
Name of Insured on your car policy:_____
Medical Payment Coverage?_____ Uninsured Motorist Coverage?_____

Other Party Car Insurance Company:_____
Address:_____ City/State/Zip:_____
Adjuster:_____ Phone:_____
Agent:_____ Phone:_____
Policy #:_____ Claim#:_____
Medical Payment Coverage?_____ Uninsured Motorist Coverage?_____

Name of your personal M.D. _____ Phone:_____
Date you first saw any Dr. after accident:_____
Address:_____ City/State/Zip:_____
Any prior auto injuries?_____ Work related injuries?_____

Write any ambulance, Hospitals, M.D., Chiropractor, Dentist, Acupuncturist, PT, etc., since accident.

NAME	TYPE	PHONE #

PATIENT NAME:_____ DATE OF BIRTH:_____ DATE:_____

Please fill in all symptoms you currently have that you <u>DID NOT HAVE</u> before accident.

<u>Orthopedic & Musculoskeletal Symptoms</u>

- ☐ "Clunk" sound with neck movement
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain Left / Right
- ☐ Upper Arm Pain Left / Right
- ☐ Elbow Pain Left / Right
- ☐ Forearm Pain Left / Right
- ☐ Wrist Pain Left / Right
- ☐ Hand Pain Left / Right
- ☐ Hip Pain Left / Right
- ☐ Upper Leg Pain Left / Right
- ☐ Knee Pain Left / Right
- ☐ Lower Leg Pain Left / Right
- ☐ Ankle Pain Left / Right
- ☐ Foot Pain Left / Right
- ☐ Jaw Pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face Pain
- ☐ Chest Pain
- ☐ Stomach Pain
- ☐ Bruise/Contusion to _____
- ☐ Abrasion/Scrape to_____
- ☐ Other Symptom _____

<u>Neurological Symptoms</u>

- ☐ Numb/Tingling arm/hand Left / Right
- ☐ Numb/Tingling leg/foot Left / Right
- ☐ Weakness arm/hand Left / Right
- ☐ Weakness leg/foot Left / Right

<u>Symptoms Associated with Injuries</u>

- ☐ Range of Motion Problems
- ☐ Headaches
- ☐ Muscle Spasms
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Sleep Disruption
- ☐ Radiating Pain
- ☐ Anxiety
- ☐ Depression
- ☐ I am taking over the counter pain meds

<u>Brain/Neuropsych/MTBI Symptoms</u>

- ☐ Wanting to be along
- ☐ Sleepiness
- ☐ Nausea/Vomiting
- ☐ Difficulty Concentrating
- ☐ Day Dreaming/Staring Mindless
- ☐ Mood Swings
- ☐ Agitation
- ☐ Sadness or Tearful
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Disoriented
- ☐ Confused
- ☐ Difficulty Speaking
- ☐ Feelings of Isolation from Others
- ☐ Attention Problems
- ☐ Appetite Change
- ☐ Pupils Different Sizes
- ☐ Room Spins/Woozy Feeling
- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Difficulty Focusing
- ☐ Very Tired
- ☐ Dozing during the day
- ☐ Personality Changes
- ☐ Can't remember numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with add/subtract
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ☐ Difficulty Remembering Things
- ☐ Re-reading things to understand
- ☐ Anger
- ☐ Difficulty making decisions
- ☐ Change in sexual functioning
- ☐ Reduced confidence
- ☐ Apathy (don't care)
- ☐ Irritable
- ☐ Change in sense of taste/smell
- ☐ Flashbacks to accident
- ☐ Hearing Problems
- ☐ Difficulty planning/organizing

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 NAME:_____ **DATE OF BIRTH:**_____ **DATE:**_____

HEALTH HISTORY: (PRIOR TO ACCIDENT)

Date of Last : Physical Exam:_____ Spinal X-ray:_____ Blood Test:_____
Spinal Exam:_____ Chest X-ray:_____ Urine Test:_____
Dental X-ray:_____ MRI, CT-Scan, Bone Scan:_____

Please check to indicate if you HAVE HAD the following:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lumps
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine/Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ STD
- ☐ Stroke
- ☐ Suicide Attempts
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Thyroid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Whooping Coughs
- ☐ Other:_____

Are you pregnant? Yes No Due Date:_____

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy
Work Activities: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Habits:
- ☐ Smoking — Packs/Day:_____
- ☐ Alcohol — Drinks/Week:_____
- ☐ Coffee/Caffeine Drinks — Cups/Daily:_____
- ☐ High Stress Level — Reason:_____

Injuries/Surgeries that you have had: **Date(s):**

Falls:_____ _____
Head Injuries/Concussion:_____ _____
Broken Bones:_____ _____
Dislocations:_____ _____
Surgeries:_____ _____
Auto Injuries/Work Injuries:_____ _____

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

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*****

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

CANCELLATION & MISSED APPOINTMENT POLICY

Our office policy regarding missed appointments is as follows:

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:_____

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

HEALTH INSURANCE WAIVER

I hereby direct you, as my medical provider, not to bill or utilize my personal health insurance for any of the treatment rendered by you and your office for injuries sustained in the incident for which I am now seeking treatment.

I believe, and have told you as my provider, that the incident was not my fault. I do not wish to be penalized in any manner for someone else's wrongdoing. My health insurance rights may be adversely affected, such as limiting my total number of office visits to a yearly maximum and using them for the injuries from this incident may result in me losing that insurance entitlement for future office visits. Or, I do not wish to be responsible for any co-pays, deductibles or incur costs for non-covered services, or for some other reason personal to me. I desire, and choose, to preserve my health insurance visits and co-pays or deductibles for any similar future medical care where I can then choose to use my healthcare coverage.

Consequently, while you are allowed to bill my auto med-pay policy if med-pay is available, you are instructed not to bill my healthcare insurance. This directive is effective immediately and covers me from the date of my first visit with your office related to this incident, and continues until the conclusion of my treatment for these injuries. I make this directive voluntarily, of my own preference and without any coercion or duress of any kind by you or your staff members.

I understand that by choosing this option, I agree that I shall not rescind this directive once given unless that rescission is given in writing by me within fourteen (14) calendar days of signing this directive. Otherwise, you, as my medical provider, would likely be past the time deadline for the submission of my bills for payment to my health insurer, or I would be creating other problems for the payment of your services under my healthcare plan. I will be solely responsible to notify any attorney I now or later retain of this directive. In the event of any litigation arising under this directive, the prevailing party shall be entitled to recover their reasonable attorney's fees and costs. Venue for any litigation arising out of this incident shall be where the medical services were provided.

_____ _____

Patient Signature/Guardian **Date**

Patient Name:_____

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

MEDICAL LIEN

I, the undersigned patient (or legal guardian of a minor), grant to Optimal Physical Therapy (hereafter "medical facility") a lien upon the recovery of any and all proceeds from any source obtained through settlement, judgment, for any medical services rendered to me or the minor, for treatment of injuries sustained or the exacerbation of any medical condition(s) (hereafter "treatment") that I or the minor have indicated, believe or did in fact arise out of an incident that occurred on or about the date set forth below (hereafter "incident"). I further authorize the medical facility to furnish my attorney with a full report of the examinations, diagnoses, treatments, prognoses, as well as billings for treatment from this incident. I hereby notify and authorize you, my attorney, to pay directly to the medical facility the unpaid amount due for services rendered.

I understand that apart from this lien, I am directly and fully responsible to the medical facility for all medical bills submitted by it for services rendered, even for bills incurred for the minor (as indicated below) who may reach the age of majority, for which I may be required to make a lump sum or periodic payments, at the election of the medical facility. This lien is made solely for said medical facility's additional protection, and in consideration of its awaiting payment. Except as otherwise provided below, I intend for this lien to continue until all charges have been satisfied. I agree that the statute of limitations of my obligation to pay is tolled and does not begin to run while the medical facility is awaiting payment by way of this lien. I further understand that the payment of services is not contingent upon any settlement, judgment, or verdict that the minor or I may eventually recover.

Except as provided below, I agree never to rescind this lien, and I do not grant any attorney that may represent the minor or me the right to rescind it. However, if my first attorney does not promptly sign, acknowledge and return this lien to the medical facility within 10 (ten) days of receipt of this lien, or if the first attorney for any reason (e.g., withdraws, resigns, is released by me, or substituted by another attorney) no longer represents me or the minor child for injuries arising from this incident, then the Irrevocable Assignment of Proceeds that I have signed with this medical facility supersedes this lien and takes immediate effect. Alternatively, if an attorney modifies this lien in any way, then the Assignment of Proceeds supersedes this lien and takes immediate effect when the modification occurs. I agree to promptly notify medical facility of any change of my address or change or addition of attorney(s).

To my attorney: Please acknowledge this medical lien by signing below and returning it to the medical facility's office.

Date of Incident: _____ _____
Print Name

Date: _____ _____
Signature of Patient or Legal Guardian of Minor

I, the undersigned attorney, state that I am the attorney of record for this patient; I acknowledge that I am in receipt of this lien; and I agree to observe its terms by withholding the sums from any settlement, judgment or verdict that are owed to the medical facility, for their compensation or benefit. I also agree to promptly (1) notify the medical facility if I discontinue representation of this patient/client, and to (2) provide any subsequent attorney of the patient for this incident a copy of this lien, along with all of the medical facility's records and billings in my or my law firm's possession. In the event this lien is litigated, the prevailing party will be awarded attorney's fees and costs.

_____ _____
Attorney Name Attorney Signature

_____ _____ _____
Attorney Phone Number Attorney Fax Number Attorney Address

Please sign, date and return one copy to medical facility's office within 10 days after receipt. Also keep one for your records.

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 Name: _____

DOB _____ SSN (last four): _____ DL State and No. _____

Automobile Insurance Company: _____

Claim No(s).: _____

Date of Incident _____

ASSIGNMENT OF PROCEEDS

I, the undersigned Patient (or as legal guardian of the minor Patient), (also referred to below as "Patient") of Optimal Physical Therapy ("Medical Provider"), without assigning any cause of action to this Medical Provider, unconditionally and irrevocably assign the proceeds of any settlement, judgment or verdict, up to the full amount of the unpaid medical services rendered by Medical Provider to Patient relating to the Date of Incident. I authorize these proceeds to be paid directly to GDP Consulting Inc, located at 8010 W. Sahara Ave., Suite 260, Las Vegas, Nevada 89117. I understand and agree that said office is authorized to contact the Insurance Company and me on behalf of the Medical Provider, to obtain information concerning the facts and status of Patient's case (e.g., completion of care, settlement status, insurance company information, etc.). Payment to a Patient, if a minor, shall be made by way of a minor's compromise, as required by law. The total amount owed, when it becomes a sum certain, will be provided to Insurance Company from one or more of the following sources: Patient, Medical Provider or attorney.

Upon execution of this agreement, I authorize and direct the Medical Provider or its attorney, to furnish the Insurance Company with all reports, findings, interpretations, impressions, treatments, diagnoses, and/or diagnostic studies that Medical Provider may perform or order for Patient received relating to the Date of Incident.

I fully understand that this assignment of proceeds is contingent upon the outcome of my claim or case, and if there is no recovery from the Insurance Company, or if less than the full amount is assignable to the Medical Provider then this assignment will not satisfy my obligation to pay the Medical Provider in full for services rendered. I fully understand that I remain directly and fully responsible to Medical Provider for all unpaid balances of medical bills associated with the services rendered to Patient, whether or not there is any financial recovery from the Insurance Company or other source. I agree that the statute of limitations for the Medical Provider to take action for the collection of any unpaid balance commences (1) six years after it is determined that this assignment of proceeds will not satisfy the amount owed or (2) six years after day of Patient's or Patient's parent/legal guardian's last payment towards the amount owed, whichever is later. The balance owed will accrue interest at the rate of 18 percent per annum from the date of the statute of limitations begins to run. Collection fees shall be the responsibility of the Patient.

If Patient does not initially retain an attorney, but later decides to retain one, then I agree to promptly (1) furnish Medical Provider with the attorney's contact information, and (2) notify Patient's attorney concerning existence of this Assignment of Proceeds. In the event that the Patient is paid by way of settlement, judgment or verdict, Patient agrees not to accept any money from either the Insurance Company or Patient's attorney from any of the proceeds that have been assigned to the Medical Provider. Medical Provider shall be paid in full out of the first proceeds of any money paid by Insurance Company or Patient's attorney.

Date: _____ Print Name of Patient: _____

_____

Signature of Patient or Legal Guardian of Minor Patient

Medical Provider acknowledges that GDP Consulting Inc is granted limited power of attorney to enforce this Assignment of Proceeds, and to receive, endorse and deposit into its trust account any funds received.

Date: _____ Authorized Representation of Medical Provider: _____

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

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient Name (Printed):_____

Date of Birth:_____ Social Security Number: XXX-XX-_____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider, or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statement to Henderson Physical Therapy dba Optimal Physical Therapy.

I agree that this authorization will remain valid up to one year of the signed date, unless revoked by delivery of written notice to Optimal Physical Therapy.

I hereby designate the above-named company and its claims personnel as my designated representative, pursuant to NCGS Sec 90-411 for the purpose of obtaining copies of my medical records, the production of which is authorized herein.

I understand that I (or my representative) am entitled to receive a copy of this authorization. A photocopy of this form may be accepted as the original.

I (or the patient named above) have received health care treatment from the following providers:

_____ _____
Provider Name Phone

_____ _____
Provider Name Phone

_____ _____
Provider Name Phone

Please send records to:

Optimal Physical Therapy
129 W. Lake Mead Parkway, Ste. 2
Henderson, NV 89015
Phone: 702.564.6712
Fax: 702.564.4838

_____

Signature of Patient or Legal Representative Relationship to Patient Date

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security Number:_____

Date of Injury: _____

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to Complete Injury Management for the purpose of review and evaluation in connection with a legal claim.

I agree this authorization will remain valid until the conclusion of my claim. I understand I have the right to revoke this authorization at any time and must do so in writing.

I understand I am entitled to a copy of this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand signing this authorization may not condition treatment, payment, enrollment or eligibility for benefits.

TO: _____

Name of Healthcare Provider/Physician/Facility **Phone**

Please send records to:

Complete Injury Management
7380 West Sahara Avenue, Suite 110
Las Vegas, NV 89117
Phone: 702.227.4878
Fax: 702.272.2013

_____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

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
P: (702) 564-6712 | F: (702) 564-4838
Email: info@optimalptlv.com Website: Optimalptlv.com

PENALTY OF PERJURY

I _____, declare under penalty of perjury, according to the laws of the state of Nevada, that the accident/injury dated _____ is a legitimate one, not contrived or feigned in any way and that the injuries I sustained were as a result of the above-mentioned accident/incident.

I furthermore declare that I have been present and received therapy on every date that I have signed/initialed.

Date:_____ **Printed Name of Patient:_____**

Signature of Patient/Guardian:_____