Optimal LLC
PHYSICAL THERAPY & REHABILITATION

Patient Intake Questionnaire

Name: _____DOB: _____ Age: ____Date: _____

Emergency Contact Name: _____ Home/Work Phone: _____
Relationship to You: _____ Cell Phone: _____

Mechanism of Injury:

- Date of onset:_____
- Was there a specific injury? Yes / No; If yes, what happened?

  _____

  _____

Main complaint/restriction:

- Please describe your main complaint_____
- What makes your complaint better? _____
- What makes your complaint worse? _____
- Does this complaint limit your ability to perform your normal daily activities? Yes / No; If yes, what are your current limitations (home, work, recreational)? _____

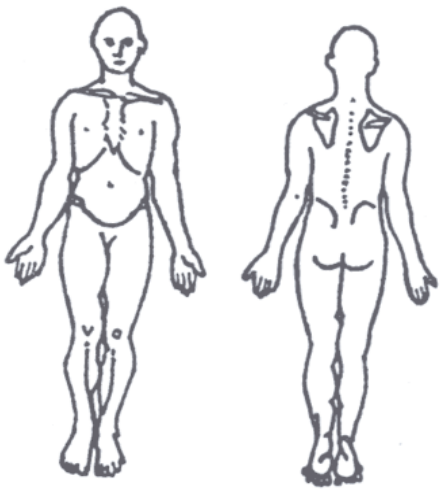
  _____

Pain Scale:

Please rate your pain on a 0 to 10 scale; 0 = no pain and 10 = unbearable pain

- Currently:_____
- Best in the last 24 hours:_____
- Worst in the last 24 hours:_____

Draw pain areas on body diagrams



Aching/Throbbing: xxxx
Numbness/Tingling: 0000
Sharp/shooting: ////
Burning: ++++
Other: #####

Medical/Surgical History:

- What diagnostic tests have you had for this complaint? (circle all that apply)

  X-Ray / MRI / CAT Scan / Bone Scan / Other ( )
  Test(s) Results: _____

- What treatment have you had for this complaint? (circle all that apply)

  Physical Therapy / Chiropractic / Injections / Surgery / Other ( )
  When? _____

- Please check any medical conditions that you have, or have had in the past.
  - o High Blood Pressure
  - o High Cholesterol
  - o Diabetes
  - o Chronic Heart Failure
  - o Arthritis — Please describe: _____
  - o COPD
  - o Stroke
  - o HIV/AIDS — When diagnosed: _____
  - o Cancer — Please describe: _____
  - o Pacemaker
  - o Depression
  - o Anxiety
  - o Traumatic Brain Injury
  - o Seizures
  - o Osteoporosis
  - o Pregnancy
  - o DVT (blood clots)
  - o Recent change in bowel/bladder — Please describe: _____
  - o Unexplained weight loss/gain — How much?: _____
  - o Other — Please describe: _____

- Please list relevant surgeries: _____

  _____

- Please list allergies: _____

- Please list medications you are currently taking:_____

  _____

Patient Goal:

- What is/are your goal(s) for physical therapy? _____

  _____

By signing below, I attest that I have personally reviewed the information on this sheet.

Patient Signature: _____Date:_____

Therapist Signature: _____Date: _____

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Patient Authorization

Patient Name (please print) _____

Consent to Treatment
All information provided herein is true and correct. I hereby consent to evaluation and treatment. I am responsible for notifying Optimal Physical Therapy And Rehabilitation, LLC ("Optimal") of any changes in my health or billing information.

Release of Information
I give permission for Optimal to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize Optimal to obtain medical records and/or professional information from my physician and other medical professionals as it relates to my treatment. Information without patient identifiers may be used for quality assurance purposes.

Assignment of Benefits
I authorize payment directly to Optimal. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Optimal. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Summary of Billing Procedures

***Private Insurance*:** Optimal will bill my insurance company and make every effort to collect on my claim. I am responsible for any co-payment, co-insurance, and/or deductible that may be due.

***Worker's* Compensation:** I pay nothing out-of-pocket as long as my carrier pre-authorizes treatment.

Medicare: After the deductible for Part B services have been met, Medicare will pay for 80% of allowable charges. Medicare will only pay up to $1,870 for combined physical therapy and speech and language pathology services. All services rendered above this limit will be my responsibility. As a courtesy, Optimal will bill my secondary insurance to recover the additional 20% and/or the deductible. If I do not have secondary insurance or if they do not pay, I will be responsible for the additional 20% and/or the deductible.

***Motor Vehicle Accidents*:** I understand that Optimal will bill the automobile insurance for services rendered. Should benefits become exhausted, I authorize Optimal to bill my primary health insurance. If I do not have health insurance, I will be responsible for payment.

Litigation: If my injury or accident involves legal proceedings, I acknowledge responsibility for payment at the time of service. Optimal does not wait for settlement or payment.

Financial Agreement: I understand that any unpaid balances are at risk for collections and that I am responsible for any collections or attorney fees. Payments received after thirty (30) days will accrue 2% interest.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatment unless agreed to in writing by myself and a representative of Optimal.

By signing below, I acknowledge that I have read and understand the information provided above.

Patient or Guardian Signature: _____Date: _____

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NO SHOW AND CANCELLATION POLICY

Patient's Name: _____ **Date of Birth**:_____

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointments are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs and to contain our fees, we maintain a No Show/Cancellation Policy for all our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Cancellations can be done over the telephone or by email. Patients will not be charged for an office visit if cancellation is made 24 hours before their appointment. In the event an appointment is missed or cancelled with less than 24 hours notice or no notice, a $30 charge will be billed to the patient. If three no-shows or same day cancellations occur, we reserve the right to discharge the patient from physical therapy.

My signature below indicates that I have read and understand these policies.

_____ _____

Patient or Responsible Party Signature ***Today's Date***

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PHYSICAL THERAPY & REHABILITATION

NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Your Health Information

This notice is to inform you of the process by which medical information about you may be used and disclosed, and how you as our patient can get access to this information.

Treatment: Your health information may be used by staff members of Optimal Physical Therapy and Rehabilitation, LLC or disclosed to other health care professionals for the purpose of evaluating and treating your health problems and ascertaining your medical conditions. For example, progress notes and reports as well as initial evaluations and reevaluations will be available in your medical record to all health professionals who may provide care or who may be consulted by members of our staff.

Payment: Your health information may be used to seek payment from your health plan or other types of insurers from whom you subscribe for insurance coverage, or from credit card companies you may use to pay for services. For example, your health insurer may require that we send them information on dates of service, treatment received, and the medical problem necessitating the treatment.

Health Care Operations: Your health information may be used statistically to provide operational and budgetary information to support the services provided by Optimal Physical Therapy and Rehabilitation, LLC. For example, auditing of charts may be done to evaluate the quality of care provided at this facility.

Law Enforcement: It may be necessary to disclose your health information to law enforcement agencies, without your authorization, to comply with government audits and or inspections, to comply with on-going law enforcement investigations, or mandated reporting to government agencies. In addition, your records may be subject to legal subpoena by law enforcement agencies.

Public Health Reporting: Should it be required by law, your health information may be disclosed to public health agencies. An example might be that we are required by law to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require your Authorization: Disclosure of your health information, or use of it for any purpose other than those described above requires your specific written authorization. You have the right to change your mind about such disclosure, and may express a revocation of same in writing to Optimal Physical Therapy and Rehabilitation, LLC. It must be noted that if you do revoke authorization to disclose medical information, it will not affect or undo any use of or disclosure of information that occurred before you notified Optimal Physical Therapy and Rehabilitation, LLC of your decision to revoke.

Appointment Reminders: Your health information will be used by our staff to provide you with appointment reminders.

Information about Treatments: Your health information may be used to send you information on the treatment or management of your medical problem, or of products and/or services, literature, or new technology that you may find of interest.

YOUR HEALTH INFORMATION RIGHTS:

You have certain rights under the Federal privacy standards. These rights include:

- ❑ Right to request restrictions on the use and disclosure of your health information
- ❑ Right to receive confidential communications concerning your medical problems and treatment.
- ❑ Right to inspect and copy your health information
- ❑ Right to amend and/or submit corrections to your health information
- ❑ Right to receive an accounting of how and to whom your health information has been disclosed
- ❑ Right to receive a printed copy of this notice

OUR HEALTH INFORMATION DUTIES:

We are required by law to maintain the privacy of your protected health information, and to provide you with a copy of this notice of privacy practices. In addition, we are required to abide by the privacy policies and practices described in this notice.

OUR RIGHT TO REVISE PRIVACY PRACTICES:

As permitted by law, we reserve the right to amend or modify our privacy practices and policies from time to time. Such changes may be required by changes in Federal or State statute or regulation. Such revisions will be applied to all protected health information that we maintain, and will be available at our facility upon your request.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION:

As permitted by Federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may request a form from us to access your protected health information by contacting Hadassa Roberts or Paula Warnsman, the privacy officers.

COMPLAINTS:

If you wish to submit a complaint or comment regarding our privacy practices, or if you believe your privacy rights have been violated, you may send a letter outlining your concerns to:

Hadassa Roberts and/or Paula Warnsman
Optimal Physical Therapy and Rehabilitation, LLC
1738 Elton Road, Suite 230
Silver Spring, MD 20903

You may also file a written complaint with the Office of Civil Rights. Effective date of this notice is February 14, 2011.