Reset Form

Optimum Performance Physical Therapy, LLC

Patient Information:

Name: _____DOB: _____SS# _____

Address: _____

Phone: (H) _____ (W) _____(C) _____

Sex: Male ○ Female ○ Marital Status: M S D W Email: _____

Employer Name/ Address: _____

Referring Physician: _____(P) _____

Primary Care Physician: _____(P) _____

Body Part: _____ Injury: _____ Surgery: No

Insurance Information:

Primary Insurance: _____ Policy # _____ Group # _____

Policy Holder: _____ DOB: _____SS# _____

Phone # _____

Secondary Insurance: _____Policy # _____ Group # _____

Policy Holder: _____ DOB: _____SS# _____

Phone # _____

WKCP (Worker's Compensation)

Carrier's Name: _____ DOI: _____ Claim #: _____

Billing Address: _____

Adjuster: _____ (P) _____ Referring Physician: _____

How did injury occur: _____ Surgery: No Type of Surgery: _____

MVA (Motor Vehicle Accident)

Name of Auto Insurance: _____ DOA: _____ Claim #: _____

Billing Address: _____

Were they seen anywhere after the accident: _____

I have reviewed the above information, other than any changes indicated above; I found the information to be correct. I have been informed of the coverage verified and understand that this is only a verbal verification of benefits, not guarantee of payment by my insurance company. This is not a guarantee of payment. We encourage you to independently verify you own insurance.

Patient Signature: Sign in office upon arrival **(seal)** **Date:** _____

Optimum Performance Physical Therapy, LLC

To ensure you receive a complete and thorough evaluation, please provide us with the most accurate, important, and up to date background information

Name: **Date:**

Occupation: **Employer:**

Date of injury or onset: **Date of Surgery:** **Type of Surgery:**

Briefly describe your symptoms:

Dominant side: ○ Right ○ Left **Involved side:** ○ Right ○ Left

How did your injury occur:

- ☐ Work incident
- ☐ Recreation/sports
- ☐ Home injury
- ☐ Degenerative process
- ☐ Unknown
- ☐ Fall
- ☐ Throwing
- ☐ Trauma
- ☐ Lifting
- Other:
- ☐ Carrying
- ☐ Pushing
- ☐ Pulling
- ☐ Overuse
- ☐ MVA
- ☐ Impact injury
- ☐ Running
- ☐ Infection

Have you had any of the following tests for this condition?

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bronchoscopy
- ☐ CT scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG
- ☐ EKG
- ☐ EMG
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NVC
- ☐ Pap smear
- ☐ Pulmonary function test
- ☐ Spinal tab
- ☐ Stool test
- ☐ Stress test
- ☐ Stress x-ray
- ☐ Urine test
- ☐ X-rays
- Other:

Test Results:

Nature of pain/symptoms:

- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Dull
- ☐ Numbness & tingling
- ☐ Occasional
- ☐ Periodic
- ☐ Pins & needles
- ☐ Radiating
- ☐ Shooting
- ☐ Stabbing
- ☐ Sharp
- ☐ Throbbing
- ☐ Other:

As the day progresses do symptoms: ○ Increase ○ Decrease ○ Stays the same

Do symptoms wake you at night? ○ Yes ○ No

What alleviates your symptoms? (Please check all that apply)

- ☐ Coughing/sneezing
- ☐ Cold
- ☐ Cutting/pivoting
- ☐ Exercise
- ☐ Going to/rising from sitting
- ☐ Heat
- ☐ Kneeling
- ☐ Jumping
- ☐ Lying down
- ☐ Looking overhead
- ☐ Massage
- ☐ Medication
- ☐ Moving
- ☐ Reaching across body
- ☐ Reaching behind back
- ☐ Reaching in front of body
- ☐ Recreation/sports
- ☐ Repetitive activities
- ☐ Rest
- ☐ Sitting
- ☐ Sleeping
- ☐ Squatting
- ☐ Standing
- ☐ Stretching
- ☐ Stress
- ☐ Sustained bending
- ☐ Swallowing
- ☐ Taking deep breaths
- ☐ Talking
- ☐ Chewing
- ☐ Twisting
- ☐ Wearing splint/orthotics
- ☐ Uneven ground
- ☐ Up/down stairs
- Other:

What aggravates your symptoms? (Please check all that apply)

- ☐ Coughing/sneezing
- ☐ Cold
- ☐ Cutting/pivoting
- ☐ Exercise
- ☐ Going to/rising from sitting
- ☐ Heat
- ☐ Kneeling
- ☐ Jumping
- ☐ Lying down
- ☐ Looking overhead
- ☐ Massage
- ☐ Medication
- ☐ Moving
- ☐ Reaching across body
- ☐ Reaching behind back
- ☐ Reaching in front of body
- ☐ Recreation/sports
- ☐ Repetitive activities
- ☐ Rest
- ☐ Sitting
- ☐ Sleeping
- ☐ Squatting
- ☐ Standing
- ☐ Stretching
- ☐ Stress
- ☐ Sustained bending
- ☐ Swallowing
- ☐ Taking deep breaths
- ☐ Talking
- ☐ Chewing
- ☐ Twisting
- ☐ Wearing splint/orthotics
- ☐ Uneven ground
- ☐ Up/down stairs
- Other:

Medications you are currently taking: (Please check all that apply)

- ☐ Antacids
- ☐ Advil/Aleve
- ☐ ibuprofen/naproxen
- ☐ antihistamines
- ☐ Decongestants
- ☐ Tylenol
- ☐ Aspirin
- ☐ Analgesics
- ☐ Steroids
- ☐ Anticoagulant
- ☐ Relaxants
- ☐ Herbal supplements

Other:

Family History: (Please check all that apply)

- ☐ Heart disease
- ☐ Diabetes
- ☐ Arthritis
- ☐ Hypertension
- ☐ Osteoporosis
- ☐ Psychological
- ☐ Stroke
- ☐ Cancer

Other:

Personal Medical History: (Please check all that apply)

- ☐ Arthritis
- ☐ Blood disorder
- ☐ High blood pressure
- ☐ Diabetes/high blood sugar
- ☐ Low blood sugar/ hydroglycemia
- ☐ Head injury
- ☐ Multiple sclerosis
- ☐ Kidney problems
- ☐ Ulcers/stomach problems
- ☐ Broken bones/fractures
- ☐ Circulation/vascular problems
- ☐ Lung problems
- ☐ Muscular dystrophy
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Infectious disease
- ☐ Developmental/growth problems
- ☐ Depression
- ☐ Osteoporosis
- ☐ Heart problems
- ☐ Stroke
- ☐ Parkinson disease
- ☐ Seizures/epilepsy
- ☐ Allergies
- ☐ Repeated infections
- ☐ Skin disease

Other:

Symptoms you have experienced in the past year: (Please check all that apply)

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Dizziness/blackouts
- ☐ Coordination problems
- ☐ Weakness in arms/legs
- ☐ Loss of balance
- ☐ Difficulty walking
- ☐ Joint pain/swelling
- ☐ Pain at night
- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Nausea/vomiting
- ☐ Bowel problems
- ☐ Weight loss/gain
- ☐ Urinary problems
- ☐ Fever/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Difficulty swallowing

Other:

Please list any recent/relevant surgeries or hospitalizations:

Date:
Date:
Date:

Do you smoke? ○ Yes ○ No Packs per day Cigars/pipes per day:

Have you smoked in the past? ○ Yes ○ No Year quit:

How many days per week do you consume alcoholic beverages? 0 How many drinks per day? 0

How often do you exercise: ○ 5+ days/week ○ 1-2 days per/week ○ Occasionally ○ Never

What do your athletic/recreational activities entail:

Other Providers you have seen for this problem:

- ☐ Acupuncturist
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Dentist
- ☐ Family practioner
- ☐ Internist
- ☐ Massage therapist
- ☐ Neurologist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Podiatrist
- ☐ Occupational therapist
- ☐ OB/GYN
- ☐ Primary care physician
- ☐ Rheumatologist

Other:

Patient Signature: Sign in office upon arrival **Date:**

Parent/Guardian Signature: Sign in office upon arrival **Date:**

OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC

Payment Policy and Procedures

Please read carefully before you sign. Your signature acknowledges understanding of items set forth herein. If you have questions regarding any sections, please ask our staff for assistance.

Release of Information

I give permission to OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer and/or related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment. I authorize OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC to obtain medical records and/or professional information from my physician and other medical professionals as it relates to my treatment. _____**initial**

Consent to Medical and Therapeutic Services

I consent to the procedures, which may be performed during the duration of care at Optimum Performance Physical Therapy, LLC. I understand that if I fail to carry out the follow-up medical care, I do so at my own risk. I also understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls, and other similar injuries, and the only alternative to entirely avoid these risks would be to forego rehabilitation altogether. I understand that I have been referred for rehabilitative treatment and care to Optimum Performance Physical Therapy, LLC. Optimum Performance Physical Therapy, LLC has described my individual treatment plan. I understand that I have the right to have any questions answered prior to receiving any treatment, including any risks or alternative treatment plan that has been prescribed by my physician and or recommended by my therapist. _____**initial**

Financial Agreement/ Guarantee of Payment and Assignment of Benefits

I request that payment of authorized insurance company(s), attorney, or legal representative, be made on my behalf to OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC. I authorize, OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, if it chooses, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, its agents and employees are hereby released from any and all liability of any nature that may arise from the release of information. I guarantee the payment of the full and entire allowed amount of all bills for services rendered for the patient. Any self-pay amounts not paid within forty-five (45) days of any notice of non-payment shall be subject to progressive collection activities up to and including referral to an independent collection agency. I also understand that all insurance coverage quoted to me and /or responsible parties are estimated and final determination of benefits and coverage lies with my insurance company. I certify that I have disclosed any and all health coverage information and I agree to provide OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, with any changes in my insurance coverage in a timely manner. I understand that as a courtesy and based on the information I provide, OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, will attempt to verify my insurance benefits. I understand that verification is never a guarantee of payment. I am responsible for payment of all co-pays and coinsurance estimates at the time of service and that these estimates may be higher than those for my primary care physician. Once my insurance company has processed claims, if the amount collected at the time of service was not enough to cover my portion, I may be billed in addition to cover my portion. Likewise, if the estimate I paid was more than my portion, I may be entitled to a refund. After 90 days of billing any secondary payer, unpaid coinsurance may become my responsibility. _____**initial**

_____
Printed Name of Patient or Guardian

Sign in office upon arrival (seal) _____
Signature of Patient or Guardian Date

OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC

Managed Care Plan Obligations

I understand that my insurance carrier may require me to have a current and complete written referral from my primary care physician. I understand that OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, recommends I check with my carrier directly. If a referral is required and is not presented prior to my treatment being rendered, my insurance may not cover all or a portion of the medical expenses incurred. In this instance, I am responsible for all uncovered charges. It is my responsibility to assist OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC in obtaining additional referrals when necessary and appropriate. Should I require additional or more specific information regarding my insurance coverage, I will contact my carrier directly. _____**initial**

Cancellation/No Show Policy

It is our desire at OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC to provide every patient with the highest quality of care and services in a timely manner. Therefore, we provide a reserved time slot for each patient so there is minimal waiting and each patient receives individual care.

In order to continue with this high quality service, we ask that you call at least 24 hours in advance if you are unable to keep your scheduled appointment. Missed appointments will result in a $40.00 no show charge. Furthermore, additional scheduled visits may be automatically cancelled.

We understand that personal schedules can be hectic, but in order to accommodate the needs of all our patients, we must maintain some level of accountability. Missed appointments on your part do not allow for continuity of care and affects your ability to reach the goals set by you and your physical therapist.
Thank you for your consideration, our staff and other patients whom may need your appointment time.
_____**initial**

HIPAA Privacy Authorization

I, _____, give OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC, permission to share my information with

- ○ Any member of my family
- ○ These Individuals:_____
- ○ Do not speak or share any of my information with family or friends, unless I give written/verbal permission

Your information may be sent to healthcare providers, health insurance companies protected by the federal privacy regulations, and to the individual(s) of your choice.

Your information may be:

- Transferred or utilized between the administration and professional staff
- Transferred from OPPT to the billing contractor who handles our billing. They have signed an agreement not to utilize your records other than those necessary to administer your insurance claim and pervade internal reports to OPTIMUM PERFORMANCE PHYSICAL THERAPY, LLC.

You may refuse to sign this authorization and it will not affect your ability to obtain treatment. You may receive a copy of this authorization at the time of signing and/or revoke this authorization at any time by sending a written notificati0on to the office _____**initial**.

_____
Printed Name of Patient or Guardian

Sign in office upon arrival (seal) _____
Signature of Patient or Guardian Date

Name:_____ Date:_____

TMJ DISABILITY INDEX

Rate your pain at this time, 0 being no pain and 10 being the worst pain. __1__/10

1. Do you or would you have difficulty with	**No Difficulty**		**Some Difficulty**				**Complete Inability**
Eating	0	1	2	3	4	5	6
Eating chewy foods (steak, bagels, gum)	0	1	2	3	4	5	6
Eating hard foods (nuts, carrots, apple, corn-on-the-cob)	0	1	2	3	4	5	6
Eating moderately soft foods (fish, noodles, peas)	0	1	2	3	4	5	6
Eating soft moods (mashed potatoes, pudding, creamed corn)	0	1	2	3	4	5	6
Eating/Drinking liquids (soups, tea, milk)	0	1	2	3	4	5	6
Talking or carry on a conversation	0	1	2	3	4	5	6

2. Do you or would you	**No Difficulty**		**Some Difficulty**				**Complete Inability**
Limit how often you eat	0	1	2	3	4	5	6
Avoid talking or having a conversation	0	1	2	3	4	5	6
Limit how long you eat	0	1	2	3	4	5	6
Change how you communicate (i.e. gesture, write notes)	0	1	2	3	4	5	6
Change the way in which your jaw moves during eating	0	1	2	3	4	5	6
Limit how OFTEN you talk or carry on a conversation	0	1	2	3	4	5	6
Limit how LONG you talk or carry on a conversation	0	1	2	3	4	5	6
Avoid talking or having a conversation	0	1	2	3	4	5	6

3. Are you satisfied with your ability to	YES		Somewhat				Not at all
Talk or carry on a conversation even though you have a jaw problem	0	1	2	3	4	5	6
Eat even though you have a jaw problem	0	1	2	3	4	5	6

4. Do you or would your jaw muscles get tight when	**None**		**Sometimes**				**All the Time**
Talking	0	1	2	3	4	5	6
Eating	0	1	2	3	4	5	6

Total Score: _____/120

Submit Form