



# Optimum Performance Physical Therapy, LLC

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## **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: \_\_\_\_\_

## **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: \_\_\_\_\_ 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:** \_\_\_\_\_ (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:

- |   |                                   |                                   |  |
|---|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Work incident        | <input type="checkbox"/> Fall     | <input type="checkbox"/> Carrying | <input type="checkbox"/> MVA           |
| <input type="checkbox"/> Recreation/sports    | <input type="checkbox"/> Throwing | <input type="checkbox"/> Pushing  | <input type="checkbox"/> Impact injury |
| <input type="checkbox"/> Home injury          | <input type="checkbox"/> Trauma   | <input type="checkbox"/> Pulling  | <input type="checkbox"/> Running       |
| <input type="checkbox"/> Degenerative process | <input type="checkbox"/> Lifting  | <input type="checkbox"/> Overuse  | <input type="checkbox"/> Infection     |
| <input type="checkbox"/> Unknown              | Other: _____                      |                                   |  |

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

- |                                       |   |  |                                       |
|---------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> Angiogram    | <input type="checkbox"/> Doppler ultrasound | <input type="checkbox"/> MRI                     | <input type="checkbox"/> Stool test   |
| <input type="checkbox"/> Arthroscopy  | <input type="checkbox"/> Echocardiogram     | <input type="checkbox"/> Myelogram               | <input type="checkbox"/> Stress test  |
| <input type="checkbox"/> Biopsy       | <input type="checkbox"/> EEG                | <input type="checkbox"/> NVC                     | <input type="checkbox"/> Stress x-ray |
| <input type="checkbox"/> Blood tests  | <input type="checkbox"/> EKG                | <input type="checkbox"/> Pap smear               | <input type="checkbox"/> Urine test   |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> EMG                | <input type="checkbox"/> Pulmonary function test | <input type="checkbox"/> X-rays       |
| <input type="checkbox"/> CT scan      | <input type="checkbox"/> Mammogram          | <input type="checkbox"/> Spinal tap              | Other: _____                          |

Test Results: \_\_\_\_\_

## Nature of pain/symptoms:

- |                                   |  |                                    |                                       |
|-----------------------------------|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aching   | <input type="checkbox"/> Numbness & tingling | <input type="checkbox"/> Radiating | <input type="checkbox"/> Throbbing    |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Occasional          | <input type="checkbox"/> Shooting  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Periodic            | <input type="checkbox"/> Stabbing  |                                       |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Pins & needles      | <input type="checkbox"/> Sharp     |                                       |

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)

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

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

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

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

<input type="checkbox"/> Antacids	<input type="checkbox"/> Decongestants	<input type="checkbox"/> Steroids
<input type="checkbox"/> Advil/Aleve	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Anticoagulant
<input type="checkbox"/> ibuprofen/naproxen	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Relaxants
<input type="checkbox"/> antihistamines	<input type="checkbox"/> Analgesics	<input type="checkbox"/> Herbal supplements

Other: \_\_\_\_\_

**Family History: (Please check all that apply)**

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Psychological	<input type="checkbox"/> Cancer

Other: \_\_\_\_\_

**Personal Medical History: (Please check all that apply)**

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Broken bones/fractures	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> Circulation/vascular problems	<input type="checkbox"/> Heart problems
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes/high blood sugar	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Parkinson disease
<input type="checkbox"/> Low blood sugar/ hydroglycemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures/epilepsy
<input type="checkbox"/> Head injury	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Allergies
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Infectious disease	<input type="checkbox"/> Repeated infections
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Developmental/growth problems	<input type="checkbox"/> Skin disease
<input type="checkbox"/> Ulcers/stomach problems	<input type="checkbox"/> Depression	Other: _____

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

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

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? \_\_\_\_\_ How many drinks per day? \_\_\_\_\_

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:**

<input type="checkbox"/> Acupuncturist	<input type="checkbox"/> Massage therapist	<input type="checkbox"/> Occupational therapist
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Neurologist	<input type="checkbox"/> OB/GYN
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Orthopedist	<input type="checkbox"/> Primary care physician
<input type="checkbox"/> Dentist	<input type="checkbox"/> Osteopath	<input type="checkbox"/> Rheumatologist
<input type="checkbox"/> Family practioner	<input type="checkbox"/> Pediatrician	Other: _____
<input type="checkbox"/> Internist	<input type="checkbox"/> Podiatrist	

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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. \_\_\_\_\_ **Initials**

### 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. \_\_\_\_\_ **Initials**

### 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 or attorney for legal action, plus attorney fees up to 33 1/3% additional and court costs. 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 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.

\_\_\_\_\_ **Initials**

\_\_\_\_\_  
Printed Name of Patient or Guardian

\_\_\_\_\_  
(seal)

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. \_\_\_\_\_ **Initials**

### Cancellation/No Show Policy/Late 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 or greater than 15 minutes late without notifying staff, **may result in a \$75 no show/cancellation fee.** Furthermore, additional scheduled visits may be automatically cancelled.

We understand that personal schedules can be hectic, but 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 who may need your appointment time.

\_\_\_\_\_ **Initials**

### 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 notification to the office* \_\_\_\_\_ **Initials.**

\_\_\_\_\_  
Printed Name of Patient or Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
(seal)  
Signature of Patient or Guardian

\_\_\_\_\_  
Date



Optimum Performance Physical Therapy, LLC  
8600 LaSalle Road  
Chester Bldg.; Suite 322  
Towson, MD 21286

## **Understanding Your First Visit**

### **Cancellation Policy**

We take great pride in the *time* and *service* we provide our patients. We know your time is valuable and we are dedicated to providing you a thorough, comprehensive treatment at each and every visit. You will always be served with the highest level of respect, integrity and in the most cost-effective manner.

We would appreciate *your* consideration as well. Patient cancellations and missed appointments are inevitable. In the event you are going to be late or cannot attend your appointment, please call Optimum Performance Physical Therapy at 410-828-OPPT (6778) to notify our staff. **Failure to notify staff may result in a \$60.00 cancellation/no show fee less than 24 hour notice.**

### **Insurance**

We participate with most insurance plans. Ultimately, it is your responsibility to know and understand the terms of your insurance coverage. Your insurance plan is a contract between you and your carrier. It is your responsibility to know whether your insurance carrier requires a referral or script. In the event that you arrive without a referral when one is required, you will be responsible for the bill or your visit will be rescheduled. We will verify benefits for Physical Therapy and help you understand your coverage. Please remember however, that benefits are not a guarantee of coverage or payment.

**Co-Payment:** This is a fixed amount set by your insurance company, which you are obligated to pay at the time of service. If your co-pay becomes a burden, please let us know. Legally we cannot waive your co-pay, but we can offer payment plans. Our main goal is to optimize your quality of life.

**Co-Insurance:** This is your cost share, usually calculated as a percentage of the cost of the service. Each plan and coverage is different. Please check with your insurance company.

**Deductible:** This is the amount you are responsible for before your insurance plan starts paying for services. Deductibles may not apply to all services. Please check with your insurance company.

### **Home Exercises**

During your time at Optimum Performance Physical Therapy, LLC, we will prescribe exercises to be completed at home. These are individually designed to focus on your biggest limitations. It is important to complete the exercises as prescribed to make gains in range of motion, strength, and function. Failure to comply with the exercise recommendations prescribed to you can adversely affect your recovery. Please make your home exercise program a top priority. We want the best for you and your health. Your active participation and diligence will help us help YOU!

If you have questions or concerns, contact us at 410-828-OPPT (6778) or [www.oppt.biz](http://www.oppt.biz).  
We look forward to working with you!



Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework or school activities.	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3. Getting into or out of the bath.	0	1	2	3	4
4. Walking between rooms.	0	1	2	3	4
5. Putting on your shoes or socks.	0	1	2	3	4
6. Squatting.	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8. Performing light activities around your home.	0	1	2	3	4
9. Performing heavy activities around your home.	0	1	2	3	4
10. Getting into or out of a car.	0	1	2	3	4
11. Walking 2 blocks.	0	1	2	3	4
12. Walking a mile.	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14. Standing for 1 hour.	0	1	2	3	4
15. Sitting for 1 hour.	0	1	2	3	4
16. Running on even ground.	0	1	2	3	4
17. Running on uneven ground.	0	1	2	3	4
18. Making sharp turns while running fast.	0	1	2	3	4
19. Hopping.	0	1	2	3	4
20. Rolling over in bed.	0	1	2	3	4
Column Totals:	0	1	2	3	4