NOTICE OF PRIVACY PRACTICES

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

Treatment, Payment, and Health care Operations: The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are; asking you about your health care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amount (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

OTHER USES AND DISCLOSURES: We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

YOUR RIGHTS REGARDING YOUR HEATLH INFORMATION: The law gives you many rights regarding your health information. You can: ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office.

OUR NOTICE OF PRIVACY PRACTICES: By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION I have read and understand Optimal Performance PT's Notice of Privacy Practices. I understand that Optimal Performance PT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how I notify the practice. I also understand that Optimal Performance PT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information

for purposes as noted in Optimal Performance PT's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time

Signature: _____ Date: _____

I would like to give permission to disclose/discuss any of my medical information kept on file at Optimal Performance Physical Therapy to the following individual/s:

Name_____ relationship _____

Name_____ relationship _____

Signature _____date _____

Optimal Performance Physical Therapy Intake Form

Name _____ Today's Date _____
Age _____ Date of Birth _____
Occupation/volunteer: The physical demands of my work (paid or unpaid) include: (e.g. sitting at computer, standing, walking)

_____
Recreational activities: I am happiest when I participate in the following:

_____
I am here today because:

_____
_____
Onset: _____
Pain: On a scale of 0-10 (0 = no pain, 10 = worst pain) I have a range of pain between (e.g. 0-5/10) ___ -___ /10. My average pain is _____/10. Right *now, my pain is* _____/10.
Irritability: When I have pain, it can last for: _____
Circle one: I was *self-referred* or *referred by*: Name _____ & credentials (MD, DDS, DO, DC, other _____)

_____
Phone:_____Fax:_____
Medications: I am taking the following medication/s _____for ____:

_____
_____
Diagnostic Imaging*: Circle one*: *I have **not** had any tests* or *I have had the following tests* (e.g. X-ray, MRI, CT, bone scan, nerve conduction velocity etc.) If you have, when & what were the results?

_____
_____
Past medical history: List all conditions, joint/region of pain, other diagnoses you have been given:

_____
I have had the following surgery/surgeries:

_____
_____
Circle one: *I do not have headaches* or *I do have headaches*, at a frequency of _____
_____ and they can last for _____
Prior treatment (PT, OT, ATC, Chiropractic, Massage, other): I have had prior treatment for
1. _____ consisting of _____
2. _____ consisting of _____
3. _____ consisting of _____
How beneficial was the prior treatment for the issues/conditions listed above? (Not helpful, a little helpful, quite a bit, a lot
1. _____
2. _____
3. _____
What types/brands of shoes do you work in or exercise in?

_____
Circle one: *I do not wear orthotics, heel lifts or inserts* or *I do wear orthotics, heel lifts or inserts*

Optimal Performance Physical Therapy Intake Form

General Health

Additional questions: Do you have, or have had, any of the following?

Cancer Yes No Location/type _____
Diabetes Yes No
Metal implants Yes No Location _____
High Blood Pressure Yes No Controlled Yes No
Seizures Yes No
Concussion Yes No
Asthma Yes No Inhaler Yes No If yes: usage _____
Anxiety/panic attacks Yes No

Females: Are you pregnant? *Circle one: yes (# weeks? _____), no, possibly*

Lower body:

Do you ever experience urine leakage when you: cough, sneeze, laugh, lift, have a strong sensation of needing to go to the bathroom or exercise?	Yes	No
Do you experience frequent trips to the bathroom that disrupt your day or do you plan trips out based on where the bathrooms are?	Yes	No
Do you experience pain, discomfort or pressure in your pelvic area when sitting or standing for prolonged periods of time?	Yes	No
Do you frequently strain to have a bowel movement or to empty your bladder?	Yes	No

Breathing:

Do you snore?	Yes	No
Do you get easily winded/short of breath?	Yes	No
Are you tired after a full night of sleep?	Yes	No
Do you have to sleep upright?	Yes	No
Have you been diagnosed with sleep apnea?	Yes	No
Do you have allergies?	Yes	No
Do you have a deviated septum?	Yes	No

Feet:

Do you have flat feet?	Yes	No
Do you have pain on the bottom of your feet when standing?	Yes	No
Does one of your feet turn out more than the other?	Yes	No
Do you feel unstable with one or both of your ankles?	Yes	No

Vision:

Do you wear contacts?	Yes	No
Do you wear glasses?	Yes	No
Do you bump into objects while walking?	Yes	No
Do you have difficulty driving at night?	Yes	No
Do you have blurry or double vision?	Yes	No
Do you feel dizzy?	Yes	No

Patient Specific Functional Scale:

Please identify up to three important activities (such as sitting, standing or walking for X amount of time/distance, sleeping, running etc.) that you are unable to do or are having difficulty with as a result of your _____ problem. Please score each activity using the scale below:

0 1 2 3 4 5 6 7 8 9 10
Unable To perform activity — Able to perform activity at the same level as before injury/problem

1. _____ /10 2. _____ /10 3. _____ /10

Optimal Performance Physical Therapy Financial Policy

This is an agreement between Optimal Performance Physical Therapy as creditor and the patient/debtor named on this form. In this agreement the words 'you', 'your', and 'yours' mean the patient/debtor. The word 'account' means the account that has been established in your name to which charges are made and payments credited. The words 'we', 'us' and 'our' refer to Optimal Performance PT.

By executing this agreement, you are agreeing to pay for all services that are received.

Payments: Unless other arrangements are approved in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain may result in a lower payment from the insurance company.

Non-contracted insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance as a courtesy to you. You agree to pay any portion of the charges not covered by insurance.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of a suit, you agree the venue shall be in Watauga County, North Carolina.
Credit History: We are members of the American Credit Bureau. You give us permission to answer questions about your credit experience with us. We have the option to report your account status to the credit bureau.
Waiver of Confidentiality: You understand if this account is submitted to an attorney if we have to litigate in court, or if your past due status is reported to the credit reporting agency, the fact that you received treatment at our clinic may become a matter of public record.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney. In addition, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility.

No Show Policy: Failure to cancel your appointment within 24 hours may result in a **$60 fee.**

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name or responsible party: _____

Signature: _____ Date: _____

Optimal Performance Physical Therapy Registration

Today's Date _____
Name: (First)_____ **MI** ____ **(Last)** _____
Address:_____
City _____ **State** _____ **Zip** _____
Home and/or cell phone: _____ **Email:** _____
Date of birth:_____ **Age** _____
Marital status: Single____ **Married** _____ **Divorced** _____
Employer _____ Job Title _____
Banner ID (If ASU) _____
Student _____ School _____
Primary Care MD _____ **Referring provider (if different)** _____
Next appointment with referring provider _____
Onset of condition/problem/ date: _____

Primary Insurance Information:
Type of insurance: *Circle*: *BCBS 80/20, BCBS 70/30, Medicare*, Work Comp, Auto, other _____
Insurance Company Name _____
Insurance Address _____
ID # _____ **Group #** _____
Insurance Co phone _____
Supplemental Insurance? If yes, Name: _____
Policy Holder Name: (First) _____ **(MI)** ____ **(Last)** _____
Relationship to Policy Holder: myself ___, spouse ____, son ____, daughter _____, other ____
Policy Holder Address (if different)_____ (city) _____, (st) _____, (zip)____
Policy Holder Date of birth _____
Policy Holder Employer _____
Policy Holder Home/cell phone _____ Work _____
SS # (if needed for insurance) _____
If Work Comp or MVA then: Claim # _____
Case manager _____
Case manager phone _____
Workmen's Compensation related? Yes _____ No ___
Motor Vehicle related? Yes ___ No ___ If yes, are you working with an attorney? Yes ___ No _
Name of attorney? _____
Emergency contact: phone _____relationship_____
How did you hear about Optimal Performance Physical Therapy? _____

CONSENT FOR TREATMENT

I, the undersigned, give permission to the practitioner/s of App State PT Clinic, to administer management necessary for my condition. (If the patient is a minor, a parent or guardian must sign).

Name_____**Date** _____

Optimal Performance Physical Therapy

I give permission to have my physical therapy records released to:

_____

_____

_____

Signature of patient

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