Consent to Treat

____ (initials) You consent to have Optimal Physical Therapy and Wellness, LLC to provide physical therapy services according to the diagnosis by your physician. It is your responsibility to provide these prescriptions as needed throughout the plan of care to continue treatment. You understand that this consent may be change, adjusted, revoked by you at any time

Cancellation/No show Policy

___ (initials) You agree that if you choose to cancel an appointment, You will do so in **24 hours** prior to your scheduled appointment. If you fail to agree, you will be responsible for paying the **full** amount of the class/session.

Payment Policy

____ (initials) You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
____ (initials) Payment is expected at time of service unless you have made other payment arrangements with us.
____ (initials) Out-of-Network Policy. (Commercial Health Plans - Does not apply to Medicare) Optimal Physical Therapy and Wellness, LLC will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. Optimal Physical Therapy and Wellness is not responsible if your health plan denies, in whole or in part, your claims for our services.

Medicare Participants

____ (initials) Medicare Policy (for Medicare Part B). If you are a Medicare beneficiary, you understand that our licensed physical therapists are not enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since we are not enrolled providers, we cannot submit claims to Medicare and Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. Therefore, by choosing our services, you are exercising your right to privacy and electing, of your own free will, not to use your Medicare benefits. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare or your Medicare Supplemental Insurance Plan will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You also understand that since we are not enrolled Medicare providers, our services are not subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan. Medicare as a Secondary Payer. If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You

understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare. Medicare Advantage Plans ("MAP"). We are not in-network with any Medicare Advantage Plans. If your MAP offers out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your MAP for reimbursement for the services your health plan covers. You are responsible for contacting your MAP to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your MAP denies, in whole or in part, your claims for our services.

Privacy Policy

____ (initials) I have received and reviewed a copy of the privacy policy for Optimal Physical Therapy and Wellness.

_____

Patient/Guardian signature

_____ _____

Printed name **Date**

Privacy Policy

Optimal Physical Therapy and Wellness is required by law to maintain the privacy of your protected health information. The information consists of all records related to your health, including demographic information, either created by Optimal Physical Therapy and Wellness or received by you or other health care providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this policy. Optimal Physical Therapy and Wellness will abide by the terms of this policy or the policy currently used in effect at the time of use or disclosure of your health information.

Your personal information will be used to contact you for arranging appointments, billing, and for evaluation and treatment purposes.

We may disclose your information without prior authorization for public health purposes, which is required by law, auditing and/or research studies.

If you provide us authorization and written permission to release your records, you may revoke this authorization at any time to cease further disclosure.

Optimal Physical Therapy and Wellness has the right to change the terms of this policy making any new provisions effective for all protected health information that we maintain. Patient may obtain the current or revised copy at any time

YOUR RIGHTS:

1) You have the right to place restrictions on the use and/or disclosure of your health information

2) You have the right to inspect and/or copy your health information

3) You have the right to amend or submit corrections to our health information

4) If you feel your privacy rights have been violated or you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the U.S. Department of Health and Human Services.

Patient Information

Name:_____ DOB:_____ Age: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Home phone: _____ Cell phone: _____ Work Phone:_____

SSN:_____ Email address:_____

Occupation/Sport:_____

Spouse/Guardian:_____ Relation to patient: _____

Address:_____ City: _____ state:_____ Zip:_____

Home Phone number:_____ Cell number:_____

Emergency contact: _____

Name Phone number

Primary Physician:_____

Name Phone number

Diagnosis/Body Part:_____

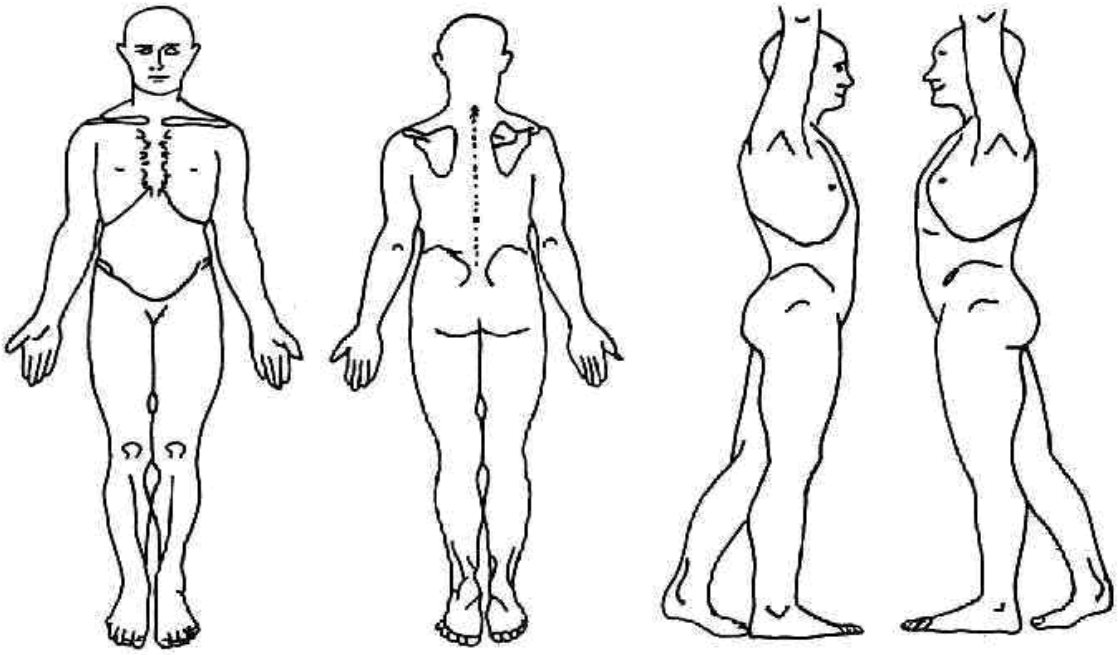
How did you hear about us:_____

Patient/Guardian Signature:_____

Name printed:_____ Date:_____

Health questionnaire

Please mark an "X" on the body chart where you experience your current symptoms. Please indicate on a scale of 0-10, 0 being no pain and 10 being the worst pain your symptoms are currently.



Please circle which of the following symptoms describe your current condition

Ache Sharp Dull Numb Burning Tingling Catching Locking Popping Clicking

Shooting Stiffness Throbbing Weakness Swollen Heavy Constant Intermittent

Do you have difficulty with the following activities?

1) Sitting Yes_____ No_____
2) Standing Yes_____ No_____
3) Walking Yes_____ No_____
4) Sleeping Yes_____ No_____
5) Lifting(____lb) Yes_____ No_____
6) Reaching Yes_____ No_____
7) Dressing Yes_____ No_____
8) Other household activities_____ Yes_____ No_____

Optimal Physical Therapy and Wellness

Do you currently experience any of the following symptoms/conditions?

1) Fever/Chills	Yes_____	No_____
2) Fatigue	Yes_____	No_____
3) Nausea/Vomiting	Yes_____	No_____
4) Headaches	Yes_____	No_____
5) Dizziness/Lightheadedness	Yes_____	No_____
6) Fainting/Loss of consciousness	Yes_____	No_____
7) Double Vision	Yes_____	No_____
8) Ringing in the ears	Yes_____	No_____
9) Difficulty Swallowing	Yes_____	No_____
10) Weight Loss	Yes_____	No_____
11) Weight Gain	Yes_____	No_____
12) High Blood Pressure	Yes_____	No_____
13) Low Blood Pressure	Yes_____	No_____
14) Chest Pain	Yes_____	No_____
15) Shortness of Breath	Yes_____	No_____
16) Asthma/Wheezing	Yes_____	No_____
17) Diabetes	Yes_____	No_____
18) Abdominal cramping	Yes_____	No_____
19) Ulcers	Yes_____	No_____
20) Heartburn	Yes_____	No_____
21) Bloating	Yes_____	No_____
22) Constipation	Yes_____	No_____
23) Diarrhea	Yes_____	No_____
24) Indigestion/GERD	Yes_____	No_____
25) Loss of appetite	Yes_____	No_____
26) Feeling of Fullness	Yes_____	No_____
27) Difficulty Eating Fatty/Greasy Food	Yes_____	No_____
28) Pain with urinating/bowel movement	Yes_____	No_____
29) Urinary Frequency	Yes_____	No_____
30) Urinary Tract Infection	Yes_____	No_____
31) PMS	Yes_____	No_____
32) Urinary leakage	Yes_____	No_____
33) Coughing/Sneezing	Yes_____	No_____
34) Skin Rash/Eczema/Skin Conditions	Yes_____	No_____
35) Stroke	Yes_____	No_____
36) Difficulty Sleeping	Yes_____	No_____

Are you under the care/supervision of an MD or DO for any conditions?_____

Optimal Physical Therapy and Wellness

Have you had any previous treatment for the current condition you are seeking treatment for?_____

Is this a work related injury?_____

Please describe your current level of function?

_____

_____

Please list current medications?

_____

_____

Do you have a history of tripping/falling/stumbling?

_____

Have you been hospitalized or had any surgeries?

_____

_____

Do you smoke or have you smoked? If so, how many per day?

_____

Do you drink alcohol? If so, how many per week?

_____

Please list any additional pertinent information that may be related to your current condition?

_____

_____