Thank you for choosing OPTherapy & Wellness

In order to best serve you please provide the following information.

PATIENT INFORMATION

Name (Last, First, M.)____ **Gender** Male _____Female ____

DOB______/______/______**SSN #**________-_______-___________**Driver's License/ID**__________________________

Address____**City**__________________**State**_______**Zip**____________

Home Phone(_____)_______-__________**Cell Phone**(_____)________-_________**Work Phone**(_____)_______-_______

Email________________________________ **Appointment Reminders by** Phone ____ Text ____ Email ____ None _____

Marital Status Single_______ Married_______ Divorced______ Other_______

Employment Status Full Time_____ Part Time_____ Student_____ N/A_____

Employer/School Name______________________________**Phone**(_____)_______-________**Title/Position**__________

RESPONSIBLE PARTY INFORMATION **(Please fill out if different than patient information above)** Name of Responsible Party_____________________________________DOB______/______/______

Address__________________________________ SSN #_______-______-_______

EMERGENCY CONTACT INFORMATION

Name___________________________Relationship___________________Phone (_____)_________-____________

INSURANCE INFORMATION

Primary Insurance Company_____________________________Policy Holder's Name_____________________________

DOB______/______/______ID #__________________Group #______________Relationship to Patient______________

Secondary Insurance Company___________________________Policy Holder's Name___________________________

DOB______/______/______ID #__________________Group #______________Relationship to Patient______________

PROXY AUTHORIZATION (Release of information to others)

I hereby authorize OPTherapy & Wellness, through its appropriate personnel, to communicate with _________________________, my (circle one) husband/wife/mother/father/son/daughter/significant other/friend regarding my appointments, medical records and billing for services rendered on my behalf. I grant OPTherapy & Wellness to leave a message regarding my upcoming appointments, treatment related issues, and account information at the following number:

Phone (_____)_______-____________ Name____________________________________

How did you learn about OPTherapy & Wellness?

Physician Referral___ Google___ Facebook___ Friend/Family Member ______________Other__________________

PATIENT MEDICAL HISTORY FORM

PHYSICIAN INFORMATION

Referring Physician_____________________________________Phone(_____)_______-___________________

Address____

Next physician appointment: Date______________________________Time____________________________

Primary Care Physicain____

HEALTH HABITS

Age _____________Height _____________Weight ______________

Smoking Currently: Yes ______ No_______ Alcohol: Current _______Past _______Never _______

Do you exercise beyond normal, daily activities and chores? Yes_______ No_______

MEDICAL/SURGICAL HISTORY

Please check any of the following health conditions that you currently or previously experienced.

Musculoskeletal

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Dislocations
- ☐ Fractures/Broken Bones
- ☐ Disc Herniation/Rupture
- ☐ Swelling
- ☐ Headaches

Change in Health

- ☐ Decreased Coordination
- ☐ Fever/Chills/Night Sweats
- ☐ Numbness/Tingling
- ☐ Nausea/Vomiting
- ☐ Appetite Changes
- ☐ Unexplained Weight Loss
- ☐ Difficulty Swallowing
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Fainting
- ☐ Hearing Loss
- ☐ Vision Changes
- ☐ Bowel/Bladder Changes
- ☐ Other: _________________

Medical History

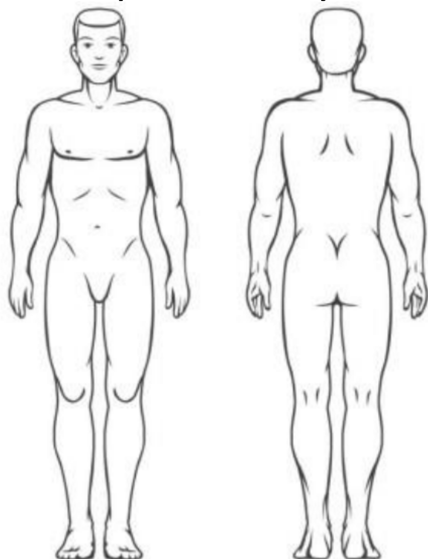
- ☐ Cancer
- ☐ Diabetes
  If yes: ☐ Type 1 ☐ Type 2
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ History of Falling
- ☐ Stroke or ☐ TIA (small strokes)
- ☐ Seizures
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Kidney Disease
- ☐ Rheumatic Fever
- ☐ Ulcers
- ☐ Glaucoma
- ☐ Gastrointestinal
- ☐ Angina/Chest Pain
- ☐ Pacemaker
- ☐ Thyroid Problems
- ☐ Communicable Disease (i.e. HIV, Hep C) If Yes, ______________
- ☐ Under Stress
- ☐ Depressed
- ☐ Currently Pregnant
  If Yes, due date_____________

What is the nature of your current injury?

☐ Work Related ☐ Chronic/Reoccurring ☐ Fall ☐ Motor Vehicle Accident

☐ Recreational ☐ Lift or Carry ☐ Insidious ☐ Surgery

Mark the part of the body we are treating:



What was the date of the injury? ___________________

What would you like to achieve by attending therapy?____

____

Please rate your pain level:

(no pain) **0 1 2 3 4 5 6 7 8 9 10** (worst)

What makes your pain worse?

____

What makes your pain better?

____

What treatments have you had for this injury?

☐ Chiropractor ☐ Acupuncture

☐ Massage ☐ Other: _______________

Did it help? ☐ Yes ☐ No

Presently are you getting: ☐ Better ☐ Worse ☐ Same

Have you had a similar injury before? ☐ Yes ☐ No

If yes, then when? ____

MEDICATIONS

Prescription/Over the Counter/Vitamins	Frequency	Dosage

CONSENT FORM/RELEASE OF INFORMATION/COMPANY POLICIES

CONSENT FOR TREATMENT

I hereby authorize OPTherapy & Wellness to render rehabilitation treatment and related services. In doing so I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch, and/or direct contact of a sensitive nature.

Initials:_______

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Initials:_______

LIABILITY

I know and agree that OPTherapy & Wellness is not responsible for loss or damage to personal valuables.

Initials:_______

WAIVER AND RELEASE

I hereby release, discharge and acquit: OPTherapy & Wellness its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

Initials:_______

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to OPTherapy, LLC, and I understand I am financially responsible for all non-covered services. I also authorize OPTherapy, LLC to release any information to process this claim.

Initials:_______

RESPONSIBILITY OF PAYMENT

I understand that I am financially responsible for all charges whether or not paid by insurance. **I understand that OPTherapy & Wellness strongly encourages me to check my benefits with my insurance company.** Should I decide not to check my benefits, I understand that any fees accrued that the insurance company does not pay will be my responsibility. All balances are due within 30 days. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principle amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, all court costs, and balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure payment of said medical practices by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence. AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

Initials:_______

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and fully understand OPTherapy & Wellness' Notice of Privacy Practices. I understand that OPTherapy & Wellness 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 my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that OPTherapy & Wellness 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 OPTherapy & Wellness' Notice of Privacy Practices.

Initials:_______

CANCELATION NOTICE REQUIREMENT

OPTherapy & Wellness is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. We require a notice by phone by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, you will be charged $55.00 for the missed appointment.

Initials:_______

Please note that refusal to sign this form does not change responsibility for payment in any way.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

____

Printed Name of Patient

______________________________________   _____________________

Signature of Patient or Legally Responsible Person   Date

______________________________________   _____________________

Printed Name of Above (of not the patient)   Date