OPTHERAPY & Wellness | PATIENT INTAKE PAPERWORK

Date _____ Legal Name _____ Date of Birth_____
(First) (Last) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Preferred Name or Nickname_____

Driver's License # _____ Male/Female_____ Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow/Widower

Cell Phone _____ **To receive appointment reminder text messages, please check here ☐**

Preferred method of communication (circle one): Email Home Phone Cell Phone

What is your primary language? _____ Do you need an interpreter? ☐ Yes ☐ No

Employer Name _____ Employer Phone_____

Employer Local Address _____

HR Department Contact _____ HR Dept. phone _____

How did you hear of OPTherapy & Wellness? (Please circle one below)

Advertisement • Internet • OPTherapy & Wellness Website • School • Club Sport • Insurance • Professional Sports Team • Race • Endurance Training Group • Location/Signage • Physician Referral •

Other Please specify name/organization: _____

Consent to Email Communication

I agree to receive email communication regarding appointment updates and marketing communication from OPTherapy & Wellness Physical Therapy at the following email address: _____

Consent to Verbal Communication

I give permission to the following person(s) to receive detailed verbal information regarding my appointments, medical care, billing and payment information. I understand this **DOES NOT** authorize the disclosure of my written health information.

Name _____ Relationship _____

Name _____ Relationship _____

*I understand **OPTherapy & Wellness** personnel may call my home phone number or other alternative number and leave a voice mail or in person in reference to appointment reminders, insurance or billing items. I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.*

Emergency Contact Information

Person to contact in case of an emergency:

_____ _____ _____
Name Telephone Number Relationship

Physician Information

Referring Physician _____ Phone _____

Address _____

Next physician appointment: Date _____Time_____

Do you have a Primary Care Physician? Yes No

If yes, would like us to send copies of correspondence to your primary care physician? Please complete:

Primary Care Physician _____ Phone _____

Address _____

If you have any questions, please contact the OPTherapy & Wellness office:

6606 Lawndale St. Ste. 200 Houston, TX 77023 | tel: 832.400.2678 | fax: 832.234.8863 | email: info@optherapywellness.com

OPTHERAPY & Wellness | PATIENT INTAKE PAPERWORK

Health Insurance

Primary Insurance Company_____ ID#_____ Group #_____
Policyholder name_____ Relationship_____ DOB_____

Secondary Insurance Company_____ ID#_____ Group #_____
Policyholder name_____ Relationship_____ DOB_____

Auto Accident

Is this an Auto Accident? ☐ Yes ☐ No Date of Accident_____
In what City and State did this occur? _____ Is this a lawsuit? ☐ Yes ☐ No
Attorney/Firm Name _____ Attorney Phone _____

Work Comp

Is this an approved Workers Comp Injury? Yes No Date of Injury_____
In what City and State did the injury occur? _____ Job Title _____
Attorney/Firm Name _____ Attorney Phone_____

**Please make sure Employer information is filled out on previous page.*

Medical History

Age_____ Height_____ Weight_____

Onset date/Surgery date_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?

☐ 0-25% of the day ☐ 26-50% of the day
☐ 51-75% of the day ☐ 76-100% of the day

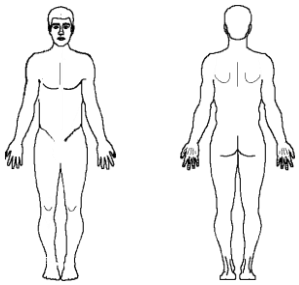
Describe the nature of your pain:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Indicate below where you have pain or other symptoms



Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Have you ever been diagnosed with dementia? Yes No
Treatment received so far for this problem (circle all that apply): Chiropractic Acupuncture Injections Physical/Occupational Therapy
Other_____

Special Tests done: X-Ray Bone Scan CT Scan MRI

If you have any questions, please contact the OPTherapy & Wellness office:
6606 Lawndale St. Ste. 200 Houston, TX 77023 | tel: 832.400.2678 | fax: 832.234.8863 | email: info@optherapywellness.com

OPTHERAPY & Wellness | PATIENT INTAKE PAPERWORK

List past Medical History (i.e. falls, surgeries, pacemaker) including dates (indicate if for current condition)

_____

_____

List any allergies (i.e. latex, adhesives) _____

Medications *Please provide names of all medications, vitamins, supplements, and over-the-counter drugs you are currently taking. We can copy a detailed list if you have one.*

Medication Name	How much (dose)	How often	How taken (circle one)
_____	_____	_____	ointment pill drop patch injection inhaler
_____	_____	_____	ointment pill drop patch injection inhaler
_____	_____	_____	ointment pill drop patch injection inhaler
_____	_____	_____	ointment pill drop patch injection inhaler
_____	_____	_____	ointment pill drop patch injection inhaler

Are you pregnant? If yes, how many weeks? _____ Have you experienced pregnancy related pain? _____

Have you utilized tobacco in the last 24 months? (Circle one) Yes No

ONLY for patients 12-20 years old. If you answered no above, have you ever utilized tobacco? Yes No

Do you drink alcohol? Yes No # of drinks per week: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things: Not at all Several Days More than one half of days Nearly every day

Feeling down, depressed, or hopeless: Not at all Several Days More than one half of days Nearly every day

Fall History

Number of falls within the last year? 0 **1** 2+

Did a fall result in injury? Yes No

Pelvic Health Question

If you are experiencing any of the problems listed below, please check the box and your therapist can discuss potential treatment options with you. Do you have a history of pelvic disorders (i.e. urge/stress incontinence, pelvic floor heaviness, pelvic/bladder or abdominal pain, irregular bowel movements)? ☐ Yes ☐ No

Social History/Leisure Activities/Exercise Routine

Home: House Condo/Apartment Group Residence Nursing Home

Do you live alone: Yes No

Are you currently working: Full Duty Light Duty Not working If not working, date last worked? _____

What is your current activity level? (Circle one below)

Sedentary Lightly active Moderately active Very active Extremely active

How many days per week do you perform a regular fitness routine? _____

OPTherapy & Wellness complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you have any questions, please contact the OPTherapy & Wellness office:
6606 Lawndale St. Ste. 200 Houston, TX 77023 | tel: 832.400.2678 | fax: 832.234.8863 | email: info@optherapywellness.com

Physical Therapy Attendance Policy
(Please read thoroughly)

OPTherapy & Wellness strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notification allows us to offer your time to another patient who is in need of services. Therefore OPTherapy & Wellness has implemented the following 24 hour cancellation policy.

- If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a fee will be charged for that appointment.
- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- All patients, regardless of insurance/third party payor, will be charged a $45 CANCELLATION FEE for each late, late-cancelled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR. This charge must be paid on or before the next appointment.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.
- Though our scheduling program is automated to send a reminder email/text, there can sometimes be a glitch in the system. It is the patient's responsibility to know when the appointment is, to check with the clinic to confirm if needed, and to arrive on time.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

All of the staff at OPTherapy & Wellness appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

_____ _____

Patient Acknowledgement/Signature Date

Consent and Statement of Financial Responsibility

1. CONSENT FOR TREATMENT: I hereby consent to, and authorize my physical therapist and other health care professionals and assistants who may be involved in my care, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist, or other healthcare professionals. 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. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin, soreness after treatment and hematoma, including, without limitation, myofascial decompression, blood flow restriction, Soft Tissue Mobilization, or Graston Technique®, Dry Needling, Cupping Therapy, High-Velocity Low-Amplitude Thrust Manipulation, and Gait Analysis. I understand that it is my responsibility to inform my physical therapist, or other health care professional if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that response to physical therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury. I give OPTherapy & Wellness permission to take photographs and videos of me for purposes such as documenting baseline function, functional progress, movement re-education and education on home exercises. I understand that these photographs and videos will be part of my confidential medical file and will not be used for any purpose beyond my medical care without my expressed written consent.

2. RESPONSIBILITY FOR PAYMENT: All co-payments and self –pay services (i.e., Dry Needling, Therapeutic Massage, Athletic Taping, etc.) are due at the time of service. I acknowledge that in consideration of the services provided to me by OPTherapy & Wellness, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide OPTherapy & Wellness with my current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that all or a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I agree to pay any such amounts which are my responsibility. I understand that OPTherapy & Wellness will bill my personal insurance carrier as a courtesy, but that I am ultimately responsible for any amounts owed. If formal collection procedures become necessary, I am responsible for any additional costs incurred as a result of such collection procedures. Please note that refusal to sign this form does not change responsibility for payment in any way.

3. ASSIGNMENT OF BENEFITS: I hereby assign to OPTherapy & Wellness all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with OPTherapy & Wellness and to provide such information as is needed to establish my eligibility for such benefits.

4. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that OPTherapy & Wellness may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and OPTherapy & Wellness administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received OPTherapy & Wellness's Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information.

_____ _____

Patient Acknowledgement/Signature Date

Attendance Policy/Credit Card Authorization Agreement

I have read or had read to me the complete attendance policy, know and understand all the terms and conditions thereof. I understand and accept these terms and conditions:

• I must cancel appointments 24 hours before the scheduled appointment time. If I fail to notify the office with an answered phone call or by leaving a voice message before that time, I agree my credit card will be charged $45 as a Late Cancellation Fee.

• If I must arrive for a scheduled appointment time no later than 15 minutes late. If I fail to arrive within 15 minutes of that time, I understand my appointment will be cancelled and, I agree my credit card will be charged $45 as a Cancellation Fee. If I am able to schedule and attend a make-up visit within the same calendar week, this previously charged fee will be credited to my account.

• If I fail to show up for a scheduled appointment without notifying the office with an answered phone call, I agree my credit card will be charged $50 as a No-Show Fee.

• I understand these fees are not covered by my insurance/third party payor, and I agree I am financially responsible for cancellation/show-show fee(s) applied to my account.

I hereby authorize OPTherapy & Wellness to charge my credit card identified below for any applicable fee in the event, I do not show and or cancel an appointment accordingly. I understand, if I later decide to change my method of payment, I must do so in person or by contacting the office with an answered phone call.

Patient or Patient's Guardian, signature. REQUIRED

_____

☐ I agree to terms listed and all information is accurate.

Name on Credit Card REQUIRED

_____

Credit Card Number REQUIRED

_____

Expiration Date REQUIRED

_____/_____
Month Year

Security Code REQUIRED

_____