OPTIMUM PHYSICAL THERAPY AND SPORTS REHAB

PATIENT NAME: _____

DOB: _____ **Sex: M / F:** _____

INSURANCE NAME: _____ **ID#**: _____

SSN: _____ **GROUP#**: _____

PRIMARY PERSON INSURED: _____

*Please provide copy of insurance card & Driver's License

*Who referred you to optimum physical therapy and sports rehab: _____

_____

PRIMARY PHONE (H / C / W): _____ SECONDARY PHONE (H / C / W): _____

E-mail: _____ ADDRESS: _____

CITY, STATE, ZIP CODE: _____

EMERGENCY CONTACT NAME/ RELATION: _____

EMERGENCY CONTACT PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____ FAX: _____

PRIMARY PHYSICIAN: _____ PHONE: _____ FAX: _____

EMPLOYER NAME: _____ PHONE: _____ FAX: _____

EMPLOYER ADDRESS: _____

5819 Highway 6, Suite 100 A Missouri City, Texas 77459
Phone: 281-969-8922 Fax: 281 – 969-8941

info@optsr.com Visit us online at www.optsr.com

OPTIMUM PHYSICAL THERAPY AND SPORTS REHAB

RELEASE OF LIABILITY & INFORMATION
(Initial on each item below)

I.____ I understand that information of medical, family and other personal history is kept confidential and have received a 'Notice of Privacy Practices' packet

2. ____ I authorize Optimum Physical Therapy and Sports Rehab, LLC to bill my insurance for reimbursement of therapy services and understand that I am responsible for the remaining balance of any unpaid claims if the services are not covered by the insurance carrier

3. ____ I have been fully informed of, consent to, and authorize the performance of all appropriate procedures and courses of treatment in the judgment of the licensed therapist

4. ____ I understand that the licensed therapist may utilize and direct other medical professionals, assistants, trainees, or therapy students regarding treatment and I accept and consent to this practice

5. ____ I have been fully informed of and understand that all healthcare involves risks and side effects, and I accept and consent to any and all reasonable and commonly-occurring risks of occupational & physical

6. ____ I acknowledge that no guarantees have been made as to the results of any therapies, and results may vary

7. ____ I give permission for Optimum Physical Therapy and Sports Rehab, LLC to obtain emergency medical treatment, if deemed

8. ____ I understand and consent that the determination of whether, when and how to provide OT and PT services is a professional healthcare decision of the licensed therapist, and the licensed therapist may decline treatment and/or discharge from treatment if the licensed therapist determines there is a lack of medical necessity for occupational & physical therapies.

9. ____ No shows or last-minute cancellations (less than 24 hours) NOT related to medical emergency will result in a $25 fee to be paid BEFORE you can be seen for your next visit. I have read ALL NINE statements listed above and understand their implications as indicated by my initials next to them and my signature below.

_____	_____	_____
Print Patient Name	Patient Signature	Date

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REASONS FOR THEARAPY:	**DATE OF INJURY:**
IS THE REASON FOR THERAPY ACCIDENT RELATED? ☐ YES ☐ NO IF YES PLEASE CHECK ONE: ☐ACCIDENT ☐AUTO ☐WORK ☐OTHER IF OTHER, PLEASE EXPLAIN:	
ARE YOU CURRENTLY RECEIVING ANY OTHER CARE FOR THE CONDITION MENTIONED ABOVE? ☐ NO ☐ YES IF YES, PLEASE LIST:	
HAVE YOU EVER RECEIVED THERAPY IN THE PAST FOR THE CONDITION MENTIONED ABOVE? ☐ NO ☐ YES	IF SO, WHEN?
PREVIOUS TREATMENT RECEIVED:	PREVIOUS TREATMENT ☐ SUCCESSFUL ☐ UNSUCCESSFUL
HAVE YOU RECEIVED THERAPY SERVICES FOR OTHER PROBLEMS/CONDITIONS DURING THIS CALENDAR YEAR? ☐ NO ☐ YES IF YES, PLEASE LIST:	
COULD YOU BE OR ARE YOU PREGNANT? ☐ NO ☐ YES	
DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?	

CONDITIONS	YES	NO	CONDITIONS	YES	NO	CONDITIONS	YES	NO
ARTHRITIS	☐	☐	DIABETES	☐	☐	NUMBNESS/TINGLING	☐	☐
OSTEOPOROSIS	☐	☐	ANEMIA	☐	☐	TYROID PROBLEMS	☐	☐
HIGH BLOOD PRESSURE	☐	☐	SWELLING IN ANKLES	☐	☐	HEADACHES	☐	☐
HEART DISEASE / HEART ATTACK	☐	☐	DEEP VEIN THROMBOSIS(DVT)	☐	☐	HEAD INJURY/ CONCUSSION	☐	☐
PACEMAKER	☐	☐	SEIZURES/EPILEPSY	☐	☐	HERNIA	☐	☐
STROKE	☐	☐	FATIGUE/WEAKNESS	☐	☐	KIDNEY/BLADDER PROBLEMS	☐	☐
VASCULAR DISEASE	☐	☐	CANCER/TUMOR	☐	☐	PREVIOUS FRACTURES	☐	☐
HYPERSENSITIVITY TO HEAT/COLD	☐	☐	RECENT WEIGHT LOSS/ GAIN	☐	☐	PREVIOUS SURGERIES	☐	☐
ASTHMA	☐	☐	HIV/AIDS	☐	☐	METAL IN BODY OR SURGICAL IMPLANTS	☐	☐
SHORTNESS OF BREATH	☐	☐	HEPATITIS	☐	☐	DEPRESSION	☐	☐
CHRONIC COUGH	☐	☐	TUBERCULOSIS	☐	☐	ANXIETY	☐	☐

DIZZINESS/LIGHT HEADEDNESS/FAINTING	☐	☐	RECURRENT INFECTIONS OR INFECTION IN PAST 3 MONTHS	☐	☐	SMOKING	☐	☐
NAUSEA/VOMITING	☐	☐	FEVER/CHILLS	☐	☐	OTHERS (PLEASE DESCRIBER BELOW)	☐	☐

IF YOU ANSWERED YES ON ANY OF THE ABOVE OR HAVE OTHER CONDITIONS NOT LISTED, PLEASE EXPLAIN AND GIVE APPROPRIATE DATE(S):	
DO YOU HAVE ANY ALLERGIES? ☐ NO ☐ YES	IF YES, LIST ALLERGIES:
ARE YOU PRESENTLY TAKING ANY MEDICATIONS? ☐ NO ☐ YES, LIST MEDICATIONS AND SPECIFY CONDITIONS:	
AT THE PRESENT TIME, WOULD YOU SAY THAT YOUR HEALTH IS:	☐ EXCELLENT ☐ VERY GOOD ☐ FAIR ☐ POOR
THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.	
_____ PATIENT/PARENT/GUARDIAN SIGNATURE	_____ DATE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME:	**DATE OF BIRTH**:
ADDRESS:	**PHONE**:

Copies of Medical Records:

☐ Most recent therapy prescription
☐ Operative Record DX-Ray and Imaging Report
☐ History & Physical
☐ Discharge Summary
☐ Lab reports
☐ Immunization Record
☐ Emergency Room Record
☐ Clinic Notes [date(s)] and Doctor's Name:

□ OTHER:

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VERBAL DISCLOSURE INFORMATION:

I understand that I am giving my permission to release information in my medical record that may include information relating to my condition and/or injury.

_____	_____	_____
PATIENT NAME	PATIENT SIGNATURE	DATE
_____	_____	_____
WITNESS NAME	WITNESS SIGNATURE	DATE

I**NFORMATION RELEASE TO:**
5819 Highway 6, Suite 100 A Missouri City, Texas 77459

PURPOSE OF DISCLOSURE:
□ Continuing Care
□ Personal
□ Insurance
□ Legal

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