OPTIMAL SPORTS PHYSICAL THERAPY

Missed Appointment Policy

We appreciate having you as a patient and are committed to helping you achieve optimal results. Your adherence to the recommended number of treatments is a vital component of your progress in physical therapy.

With the exception of emergencies, it is expected that you keep all of your scheduled appointments. If you are unable to keep a scheduled appointment, please call our office to reschedule. If you need to call after hours, please leave a message on the answering machine. We kindly ask for **24 hours advanced notice**. We reserve the right to charge a **$25 no-show fee** for a missed appointment.

In instances of repeated non-compliance with scheduled appointments, we reserve the right to discontinue care. We will inform your prescribing physician that your physical therapy service has been discontinued due to non-compliance with the prescribed rehabilitation order.

Physical Therapy Treatment Consent

I request and consent to the physical therapy evaluation and treatment performed or directed by a licensed physical therapist at Optimal Sports Physical Therapy. I understand that the physical therapist will evaluate and determine the appropriate treatment and procedures specific to my needs. The treatment will be in compliance with Montana's physical therapy practice at and may include:

Manual therapy techniques, such as spinal and extremity manipulation/mobilization and instrument-assisted techniques (i.e. cupping, ASTYM)
Neuromuscular re-education
Therapeutic activities
Therapeutic exercises
Modalities such as ultrasound, electrical stimulation, iontophoresis, heat/cold therapy

I understand that there are potential risks to treatment while receiving physical therapy. These risks may include, but are not limited to: fractures, disc injuries, cardiovascular issues, pneumothorax, bruising, increase in pain, burns and nerve injury. The therapist may not explain all potential risks at any particular visit, and I have the right to ask questions and terminate any part of the physical therapy treatment at any time.

Collections Policy

I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 50% of the account balance, including attorney/court costs will be added to the total amount due.

My signature below acknowledges that I have completely read and understand OSPT's Missed Appointment Policy, Physical Therapy Treatment Consent and Collections policy. I have had the opportunity to inquire about the above information. By signing below, I agree to the aforementioned policies and procedures.

Reviewed by:_____

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Patient Name: _____

Patient Signature: _____

Date: _____

Below is required if patient is a minor

Name of parent or Legal Guardian: _____

Parent/Legal Guardian Signature: _____

Date: _____

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Name:_____ **DOB:**_____ **Date:**_____
Primary Care Physician:_____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑changes in bowel or bladder function
- ❑nausea/vomiting
- ❑dizziness/lightheadedness
- ❑difficulty maintaining balance while walking
- ❑changes in appetite
- ❑fever/chills/sweats
- ❑pain at night
- ❑weakness/fatigue
- ❑difficulty swallowing
- ❑headaches
- ❑shortness of breath
- ❑weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑cancer: type_____ Active OR Remission
- ❑heart disease
- ❑high blood pressure
- ❑blood clot/ emboli
- ❑pacemaker inserted
- ❑osteoporosis
- ❑numbness/ tingling
- ❑rheumatoid arthritis
- ❑stroke
- ❑depression
- ❑anemia
- ❑lung problems
- ❑thyroid problems
- ❑other
- ❑diabetes (type 1/ type 2)
- ❑multiple sclerosis
- ❑kidney/liver problems
- ❑stomach ulcers
- ❑epilepsy
- ❑Parkinson's disease
- ❑weight loss/gain
- ❑shortness of breath
- ❑headaches
- ❑Alzheimer's
- ❑cardiovascular disease
- ❑cauda equina syndrome
- ❑current infection
- ❑fibromyalgia
- ❑fracture
- ❑Huntington's
- ❑immunosuppresion
- ❑lupus
- ❑muscular dystrophy
- ❑obesity
- ❑osteoarthritis
- ❑traumatic brain injury
- ❑other_____
- ❑other_____

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Do you smoke? YES NO _____pack/day

Height:_____ **Weight:**_____

FOR WOMEN (Only): Are you currently pregnant or think you might be pregnant? **YES NO**

Please list current medications:_____

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? **YES NO**

ALLERGIES:_____

Are you latex sensitive: **YES NO**

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Are you sensitive to adhesives: **YES NO**

Please list any diagnostic tests performed for this condition (x-ray, MRI, etc):_____
Please list all medical providers you have seen for this condition:_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:
1._____ 2._____ 3._____

For the injury you are seeing us for today:

Pain at LOWEST: Rate your lowest pain level in past 3 days.

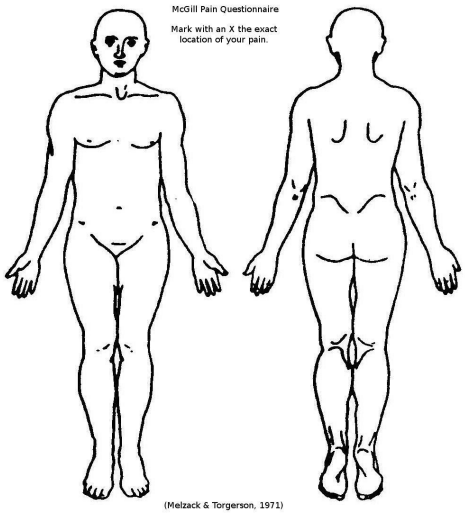
0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain Imaginable

Pain CURRENTLY: Rate your level of pain at this time.

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

Pain at WORST: Rate your highest pain level in past 3 days.

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



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Things that help to EASE symptoms:_____

Things that make symptoms WORSE: _____

Please List 1 (one) important activity you are unable or have difficulty performing as a result of your pain/symptoms. (ex. Stairs, reaching overhead) _____

Have you had previous PT for this condition? YES NO

What is your goal for therapy at this time?_____

HIPAA Compliance Patient Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Patient Signature:_____ **Date:**_____

Reviewed by:_____

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Today's Date:_____

Full Legal Name_____

Date of Birth_____ Age_____ ❒ Married ❒ Single ❒ Other ❒ Male ❒ Female

Address_____

Street **City** **State** **Zip Code**

Mailing Address_____

(If different than above) **Street** **City** **State** **Zip Code**

Patient's SS. #_____–_____–_____ **E-mail:** _____

Employer_____ Phone ( ) _____

Home Phone ( ) _____ May we leave message? ❒ Yes ❒ No

Cell Phone ( )_____ Voice message? ❒ Yes ❒ No Text message? ❒ Yes ❒ No

Work Phone ( ) _____ May we leave message? ❒ Yes ❒ No

Preferred statement method (please circle one) **Paper/US Mail** **Electronic/E-mail**

⋄**RESPONSIBLE PARTY:** Full name_____

⋄Relationship_____ Social Sec. #_____–_____–_____ Date of Birth_____

⋄Address (if different) _____

Responsible party e-mail address (if different) _____

PLEASE CIRCLE ONE: WORK COMP AUTO PRIVATE/HEATH SELF PAY

Primary Insurance Co_____ Phone ( ) _____

Address_____

Case Manager/Adjuster_____ Phone ( )_____ Ext_____

ID or Claim #_____ Date of Injury_____

Group Name_____ Group Number_____

Insured's Name/Relationship_____ Date of Birth_____

Secondary Insurance Co_____ Phone ( ) _____

Insured's ID #_____

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Group Name_____ Group Number_____

Insured's Name/Relationship_____ Date of Birth_____

Tertiary Insurance_____ Insured's Name/Relationship_____

ID# _____ Group #_____

Primary Care Physician _____Phone ( )_____

How did you hear about us? (please circle one)

Friend Family Physician referral Radio ad Social media Internet search Other _____

Appointment Reminders: (please circle one) text call email

Reviewed by:_____