Medical History

Patient Name: _____ DOB: _____ Age: _____

Reason for Therapy

Date condition began: _____

Is this a work related injury? ☐ Yes ☐ No

Date of next doctor appointment for this condition: _____

Please describe the onset and history of the current condition(s): _____

_____

Current Symptoms

Rate your symptom intensity in the past 5 days:

(0 is no pain or symptoms and 10 is worst possible pain or symptoms)

Symptoms at worst: _____ out of 10

Symptoms at best: _____ out of 10

Surgery

Did you have surgery for this condition? ☐ Yes ☐ No

Date of surgery (if applicable): _____

Type of surgery: _____

Diagnostic Tests

List any diagnostic tests you have received for this condition: _____

_____

Previous Therapy

Have you received therapy in the past 12 months? ☐ Yes ☐ No

If yes, for what condition? _____

_____

_____

Tobacco Use

Do you currently smoke? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

If yes, how many packs per day? _____

Have you smoked in the past? ☐ Yes ☐ No For how many years? _____

How many packs per day? ____ How long ago did you quit? _____

Alcohol Use

Do you drink alcohol? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

How many times per week? _____ How many drinks? _____

Allergies

Do you have any allergies to medications, food, or other substances that we need to be aware of?

☐ Yes ☐ No

Please provide details: _____

_____

_____

Medical Conditions

Do you have any medical conditions that you currently suffer from or have suffered from in the past?

☐ Yes ☐ No

List of Medical Conditions Check any medical conditions that you have a history of:

☐ Abnormal Bleeding	☐ Chronic Back Pain	☐ Diabetes Type II	☐ High Cholesterol	☐ Osteoarthritis
☐ Angina	☐ Chronic Neck Pain	☐ DVT	☐ HIV/AIDS	☐ Osteoporosis
☐ Anxiety	☐ Closed Head Injury	☐ Fibromyalgia	☐ Hypertension	☐ Psoriatic Arthritis
☐ Arrhythmia	☐ Colitis	☐ Frequent UTI	☐ Hypothyroidism	☐ PVD
☐ Asthma	☐ Congestive Heart Failure	☐ GERD	☐ IBS	☐ Rheumatoid Arthritis
☐ Bipolar Disorder	☐ COPD	☐ Glaucoma	☐ Joint Pain	☐ Scoliosis
☐ Blood Clotting Disorder	☐ Crohn's Disease	☐ Gout	☐ Lymphedema	☐ Seizure Disorder
☐ Bowel Incontinence	☐ CVA (Stroke)	☐ Heart Disease	☐ Migraines	☐ Shortness of Breath
☐ Cancer	☐ Degenerative Disc Disease	☐ Hepatitis B	☐ MRSA	☐ Sleeping Disorder
☐ Carpal tunnel Syndrome	☐ Depression	☐ Hepatitis C	☐ Multiple Sclerosis	☐ TB
☐ Cellulitis	☐ Diabetes Type I	☐ Hiatal Hernia	☐ MI/Heart Attack	☐ Urinary Incontinence

Other Conditions

Do you have a pacemaker? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

List any conditions not already included: _____

_____

Surgeries

Have you had any surgeries? ☐ Yes ☐ No

List surgeries you have had including date if known:

Type	Date	Results/Details

Medications

Do you take any medications or over the counter supplements? ☐ Yes ☐ No

Please list current medications: (include dose and frequency if possible)

Name	Dose	Frequency	Method (oral, injection, etc.)

OMPT Specialists, Inc.

29255 Northwestern Hwy
Southfield MI 48034-0002
Phone: (248) 353-1234

CONSENT FOR TREATMENT

I hereby authorize OMPT Specialists and its affiliates, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by the physician in the treatment of my condition. I further authorize OMPT and its affiliates to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment. I am assigning my therapy benefits to OMPT or its affiliates for the services in which I receive and authorize my insurance carrier to make payment to OMPT and/or its affiliates on my behalf. OMPT reserves the right to seek reimbursement from any and all insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. All records released require administrative and copying fee paid to OMPT before they are released, regardless of requestor. OMPT is HIPAA compliant with regard to information sharing policies.

Relationship to Patient:

_____ _____
Signed By Date

Patient Forms and Consents

OMPT Specialists Physical Therapy
(248) 353-1234

Financial Policy

Financial Policy: OMPT Specialists assumes no liability for any benefit information that is misquoted by your insurance carrier. It is your responsibility to be aware of your insurance coverage, limitations and terms and conditions of your policy. Benefits and verification are performed as a courtesy to you. OMPT cannot be responsible for any information that is obtained directly from your insurance carrier that is later deemed inaccurate. You are responsible for payment of any deductible, copayment and coinsurances as determined by your policy. Your insurance company does state that this verification is not a guarantee of payment. Your benefits will not be determined until they receive your claim. Charges are based on services rendered per visit and billed to the negotiated contract with each managed care plan or database mandated by the state. If additional treatment is necessary beyond your policy visit limits or dollar amount, we may consider alternative payment options.

Medicare Patients: Medicare will NOT pay for outpatient physical or occupational therapy if you are simultaneously receiving any type of health care in your home. Please make sure you are discharged before starting outpatient therapy. You will be responsible for payment of services rendered. This may include therapy, a visiting nurse or any other person who comes to your home to provide medical services to you

Cancel and No-show Policy: OMPT Specialists physical therapy strives to provide each patient with the highest quality of care. Therefore, we ask that you give us notice at least 24 hours prior to your scheduled appointment or a $25 charge will be added to your account, a no show to your appointment will have the same $25 charge. All charges must be paid before your next appointment.

Repeated no shows or late cancellations are disruptive to the optimal delivery of care and may impact insurance coverage. As a result, 3 late cancellations and/or no shows may result in loss of your regularly scheduled session time and may result in being dismissed from therapy. In the event that you are discharged from our care, your referring provider and/or claims manager will be notified of the reason for discharge from therapy.

I understand the OMPT Specialists Financial Policies as described above. I consent to receive treatment as prescribed by my provider. I authorize the release of any medical or other information necessary to process the claim or provide continuity of care. I acknowledge that I am financially responsible for any charges not covered by my insurance.

_____ _____

Signed By Date

Patient Forms and Consents

OMPT Specialists
(248) 353-1234

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

Acknowledgement of Receipt of this Notice
You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. Please call (248) 353-1234 to request a hard copy.

Who Will Follow this Notice
All physicians, licensed health care personnel, employees, staff and other office personnel. Any independent health care professional who may provide services at our office and is authorized to enter information into your medical record. All students or trainees. Any persons or companies with whom OMPT Specialists contracts for services to help operate our practice and who have access to our patients' medical information.

Our Responsibility Regarding Protected Health Information
Your 'protected health information' is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

Make sure that your protected health information is kept private.

Give you this notice of our legal duties and privacy practices related to the use and disclosures of your protected health information.

Follow the terms of the notice currently in effect.

Communicate any changes in the notice to you.

Our System
OMPT Specialists works with several agencies and referral sources. Your health information will be shared in the following manner:

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosure to your physician or other health care providers who becomes involved in your care.
Within our office for administrative activities, quality assessment, oversight and peer review.
With our billing personnel and as necessary to obtain payment for your health care services.
With your insurance company or other payers as required for payment.
With the referring agency and case manager.

With any other provider, school and/or agency with your written request or allowed through FERPA. You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.

Required by Law
We may use or disclose your protected health information if law or regulation requires the use or disclosure. We will notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Legal Proceedings
We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Parental Access
We may disclose your protected information to parents, guardians and persons acting in similar legal status.

For Health Care Operations
OMPT Specialists, staff and business associates may use and disclose medical information about you to operate this office. For example, OMPT Specialists may use medical information to call out your name in the waiting room, to review treatment and services or to evaluate the qualifications and performance of therapists in caring for you. OMPT Specialists, may also disclose information to licensing authorities or offices who evaluate qualifications and review care to determine if OMPT Specialists and its therapists can be licensed, credentialed, certified, or approved under a health plan or to treat patients at a particular facility. OMPT Specialists, may contract with other professionals or companies, such as medical record transcription services, consultants, financial advisors or legal counsel, to help us run the practice and who have agreed to follow our Notice of Privacy Practices.

Contacting You
Unless OMPT Specialists has agreed in writing to your written request to handle these matters differently, OMPT Specialists may use and disclose medical information to leave you a message or send you a letter concerning an appointment or to ask you to call concerning your care or your account. OMPT Specialists will use the contact information that you provide.

Individuals Involved in Your Care
OMPT Specialists may disclose medical information about your child to a friend or family member who is involved in your medical care, unless you object. You can object to these disclosures by notifying OMPT Specialists in writing that you do not wish any, or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, OMPT Specialists will use our professional judgment to decide whether it is in your best interest to disclose relevant information to someone who is involved in your care.

Your Rights Regarding Your Health Information
You may exercise the following rights by submitting a written request to OMPT Specialists office.

You may inspect and obtain a copy of your protected health information that we keep as a part of medical and billing records.

You may ask us not to use or disclose any part of your health information for treatment, payment, or health care operations.

Your request must be made in writing.

You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request.

We will accommodate reasonable requests, when possible.

Federal Privacy Laws
This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected information.

Changes to the Notice of Privacy Practices
OMPT Specialists reserves the right to change this notice. OMPT Specialists reserves the right to make the revised or changed notice effective for medical information already held about you as well as any information received in the future. OMPT Specialists will post a copy of the current notice in the office. The notice will remain in effect for each subsequent visit unless changed. If the notice changes, a copy will be available to you upon request.

PAYMENT FOR SERVICES AGREEMENT

Services to be Provided
OMPT Specialists will provide therapy services for you in accordance with the orders provided by the patient's physician. It is understood that licensed therapists employed by OMPT Specialists will complete the services provided. The responsible party gives permission for the patient to receive therapy services provided by OMPT Specialists.

Insurance Benefits

OMPT Specialists will verify the patients benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that the verification of benefits and authorization is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.

Assignment of Insurance Benefits

I hereby instruct and direct my insurance company to pay OMPT Specialists for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payments toward the total charges for the professional services rendered.

Release of Information for Reimbursement

The responsible party authorizes the release of information pertaining to the patient's diagnosis and course of treatment to OMPT Specialists by the patient's physician and any other therapy service providers involved in the patient's care. The responsible party also authorizes the release of information to the patient's physician and any other agencies related to reimbursement issues.

_____ _____

Signed By Date

Patient Forms and Consents
OMPT Specialists

Phone: (248) 353-1234

PAYMENT FOR SERVICES AGREEMENT

Services to be Provided

OMPT Specialists will provide therapy services for you in accordance with the therapist's Plan of Care and/or orders provided by the patient's physician. It is understood that licensed therapists employed by OMPT Specialists will complete the services provided. The responsible party gives permission for the patient to receive therapy services provided by OMPT Specialists.

Insurance Benefits

OMPT Specialists will verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that the verification of benefits and authorization is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.

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Release of Information for Reimbursement

The responsible party authorizes the release of information pertaining to the patient's diagnosis and course of treatment to OMPT Specialists by the patient's physician and any other therapy service providers involved in the patient's care. The responsible party also authorizes the release of information to the patient's physician and any other agencies related to reimbursement issues.

I give permission to OMPT Specialists to release information to my insurance company and bill for services on my behalf. I understand that authorization and verification of benefits is not a guarantee of payment and that I am responsible for any charges not covered by insurance.

_____ _____

Signed By Date