OPTIMAL PERFORMANCE & PHYSICAL THERAPIES
KENDALL HAND & PHYSICAL THERAPY

Patient Information			
First Name:	MI:	Last Name:	
Address:	City:	ST:	Zip:
Cell Phone: ( )	Other Phone: ( )		
Last 4 Digits SS#:	Date of Birth:	Sex: Male / Female	Married / Single / Other
Employer:	Email:		
Physician Information			
Referring Physician:	Physician Phone:		
Primary Care Physician:	Physician Phone:		
Insurance Information			
Primary Insurance:	ID Number:		
Subscriber's Name (if different):	Date of Birth:	Relationship:	
Subscriber's Address:	City:	ST:	Zip:
Subscriber's Home Phone: ( )	Other Phone: ( )		
Secondary Insurance:	Secondary Insurance ID#:		
Subscriber's Name:	Date of Birth:	Relationship:	
Emergency Contact Information			
Contact Name:	Relationship:		
Home Phone: ( )	Other Phone: ( )		
Other Information			
Is this work related? Yes / No	If yes, date of injury:		
Is this related to a motor vehicle accident? Yes / No	If yes, date of accident:		
Medicare Patients Only			
Are you <u>currently</u> receiving ANY home health services (including nursing, dressing assistance, bathing assistance, injections, respiratory services, physical therapy, occupational therapy or speech therapy? Yes / No **Name of Agency:**			
Yes, I would like to receive appointment reminders via text / voicemail (circle one) or No, thanks			
How did you hear about us? ☐ Physician Referral ☐ Family/Friend ☐ Other (describe): _____			

I hereby give consent for treatment for myself, or the named minor child, by the staff at OPPT and/or as directed by my referring physician. I authorize the release of any medical information necessary to process claims for these services. I authorize release of clinical information for treatment, payment and healthcare operations. I assign medical benefits payable for these services directly to OPPT. I understand that I am responsible for payment at the time of service of any applicable co-payments, co-insurance, deductibles, or any self pay charges if no insurance company or third party is being billed for treatment received.
*Splints are non-refundable and cannot be returned.

Signature: _____ Date: _____

Parent/legal guardian signature: _____ Date: _____ Relationship: _____

_____ initial

I **acknowledge** that I have received a copy of OPPT's Notice of Privacy Practices. I understand that this information describes how OPPT may disclose and use my protected health information.
If I have any questions, I can contact Beth Patterson, PT, DPT, SCS, CHC, Chief Compliance Officer at:
3903 Northdale Blvd., #111W, Tampa, FL 33624

Name: _____ Date:_____

This form contains a series of questions designed to help your Physical/Occupational Therapist evaluate your condition. This information will help your therapist provide you the best possible care. Please answer each question as accurately and completely as you can.

DOB:_____ Age:_____ Height: _____ Weight:_____

Do you have a pacemaker? Yes No Do you smoke? Yes No

Falls: Have you had two or more falls within the last 12 months? Yes No
Have you had a fall that resulted in an injury within the last 12 months? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: (Including any medication(s) you are allergic to): _____
Are you latex sensitive? Yes No

Please describe your current health (circle): Excellent Very Good Fair Poor

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

- ❑ Fatigue
- ❑ Fever/chills/sweats
- ❑ Nausea/vomiting
- ❑ Weight loss/gain
- ❑ Poor Balance/Falls
- ❑ Headaches
- ❑ Swelling in your legs/ankles
- ❑ Any skin changes/rashes
- ❑ Numbness or tingling
- ❑ Unusual muscle weakness
- ❑ Dizziness/lightheadedness
- ❑ Heartburn/indigestion
- ❑ Difficulty swallowing
- ❑ Specific food intolerances
- ❑ Changes in bowel or bladder function
- ❑ Any type of infection in the past 3 months
- ❑ Constipation
- ❑ Diarrhea
- ❑ Fainting
- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Heart Palpitations

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

- ❑ Cancer
- ❑ Heart Attack/Heart Disease
- ❑ High blood pressure
- ❑ Chest pain/angina
- ❑ Heart valve problems
- ❑ Circulation problems
- ❑ Blood clots (DVT)
- ❑ Stroke (TIA or CVA)
- ❑ Anemia
- ❑ Diabetes (Type 1 or 2)
- ❑ Infectious Diseases (HIV, Hepatitis, TB)
- ❑ Depression
- ❑ Lung problems
- ❑ Pneumonia
- ❑ Asthma
- ❑ Rheumatoid Arthritis
- ❑ Degenerative arthritis
- ❑ Bladder/urinary tract infection
- ❑ Kidney problem/infection
- ❑ Bone or joint infection
- ❑ Pelvic inflammatory disease
- ❑ Chemical dependency (i.e. alcoholism)
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Gout
- ❑ Osteoporosis
- ❑ Multiple sclerosis
- ❑ Epilepsy/seizures
- ❑ Fibromyalgia
- ❑ Stomach ulcers
- ❑ Liver problems
- ❑ Endometriosis

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ Cancer
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Abdominal Aortic Aneurysm
- ❑ Diabetes (Type 1 or 2)
- ❑ Stroke (TIA or CVA)
- ❑ Depression
- ❑ Tuberculosis
- ❑ Thyroid problems
- ❑ Blood Clots

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**

Is this something with which you would like help? **YES** **YES, BUT NOT TODAY** **NO**

Please list any medications you are currently taking (including pills, injections, and/or skin patches)

Medication	**Dosage/Frequency**	**Condition Medication Taken For**

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions**? YES NO**
Are you currently taking any anti-inflammatory medications (Aleve, Motrin, Aspirin, Ibuprofen etc)? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____

2. _____

3. _____

4. _____

Please list Sport and Leisure activities that you participate in:

_____

Please list your occupation, including activities that comprise your workday:

_____

What are your personal goals related to therapy and your recovery?

_____

Do you live alone? YES NO

Current Condition:
Treatment received so far for this problem (Physical Therapy, Massage Therapy, Home Health, Chiropractic, Injections, Heat/Ice, other)_____

Please list special diagnostic tests and results performed for this problem (X-ray, MRI, CT Scan, EMG/NCV, Blood Tests, Doppler Study, Bone Scan, Ultrasound, Cardiac Stress Test)

_____

Have you had the same or a similar problem in the past? **Yes No** If yes, how was it treated?

_____

How long did it take for you to feel better? _____

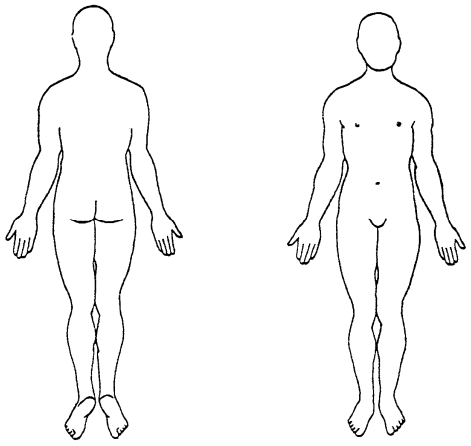
If your current symptoms are due to an injury, describe how it occurred?

_____

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O Dull/aching pain
||| Numbness
= Tingling



Date of onset of current symptoms/injury: _____

How did your current symptoms begin? gradually suddenly

Your symptoms are currently: ❑ Getting better ❑ About the same ❑ Getting worse

Your symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Please circle the number below which best represents your overall average level of function.

Cannot do anything **0 1 2 3 4 5 6 7 8 9 10** **Able to do everything**

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Optimal Performance & Physical Therapies

OPTIMAL PERFORMANCE AND PHYSICAL THERAPIES HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about our patients may be used and disclosed and how they can get access to this information. **Please review it carefully.**

Purpose of this notice: OPPT is required by law to maintain the privacy of certain confidential health care information, know as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to patients' PHI.

This Notice describes legal rights, advises of our privacy practices and outlines how OPPT is permitted to use and disclose PHI about our patients. OPPT is also required to abide by the terms of the version of this Notice currently in effect. In most situations, we may use this information as described in the Notice without permission, but there are some situations where we may use it only after we obtain or patients' written authorization, if we are required by law to do so.

Uses and Disclosures of PHI: OPPT may use PHI for the purposes of payment and health care operations, in most cases without written permission. Examples of our use of PHI:

For Treatment: This includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

For Payment: This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

OPPT will not use or disclose more information for payment purposes than is necessary. This is known as using only the minimum necessary amount to accomplish the purpose of use or disclosure. We are accountable to the Secretary of Health and Human Services to safeguard (keep secure) and protect (keep private) our patients' information.

For Health Care Operations: This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, and certain marketing activities.

OPPT is required by law to notify our patients in case of a breach of their unsecured protected health information when it has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach.

For Marketing Communications: We may use or disclose your health information to identify health-related services and products that may be beneficial to your health and we may contact you about these services.

Use and Disclosure of PHI Without Your Authorization: OPPT is permitted to use PHI without written authorization, or opportunity to object in certain situations, including:

1. For OPPT's use in obtaining payment for services provided or in other health care operations;
2. To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your insurance company);
3. To another health care provider (such as the referring physician) for the health care operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with our patients and the PHI pertains to that relationship;
4. For health care fraud and abuse detection or for activities related to compliance with the law;
5. To a family member, other relative or close personal friend or other individual involved in our patients care if we obtain verbal agreement to do so or if we give our patients an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to family, relatives, or friends if we infer from the circumstances that there is no objection. For example, we may assume our patients agree to our disclosure of personal health information to their spouse when their spouse has called us for them. In situations where our patients are not capable of objecting (because the patients are not present or due to incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to a patient's family member, relative, or friend is in the best interest. In that situation, we will disclose only health information relevant to that person's involvement in our patient care;
6. To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects or to notify a person about exposure to a possible communicable disease) as required by law;
7. For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
8. For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process.
9. For law enforcement activities in limited situations, such as when there is a warrant for the request or when the information is needed to locate a suspect or stop a crime;
10. For military, national defense and security and other special government functions;
11. To avert a serious threat to the health and safety of a person or the public at large;

12. For workers' compensation purposes and in compliance with workers' compensation laws;
13. To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law; and
14. If our patient is an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ donation and transplantation.

Any other use or disclosure of PHI, other than those listed above, will only be made with written authorization (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). Authorization may be revoked at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Rights: Our patients have a number of rights with respect to the protection of their PHI.

OPPT will permit individual to exercise patient rights.

The right to access, copy, or inspect PHI. Information held electronically will be provided in electronic form if requested by the patient. OPPT requires that requests to inspect or copy PHI be submitted in writing to our office.

The right to amend PHI. Our patients have the right to ask us to amend their written medical information.

The right to request an accounting of our use and disclosure of an individual's PHI. Our patients may request an accounting from us of certain disclosures of their medical information that we have made in the last six years prior to the date of the request. We are not required to give an accounting of information we have used or disclosed for purposes of treatment, payment, or health care operations. We are also not required to give an accounting of our uses of PHI for which we already have a written authorization for such use. To request an accounting of the medical information that we have used or disclosed that is not exempted from the accounting requirement, contact the Privacy Officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of an individual's PHI. Our patients have the right to request that we restrict how we use and disclose their medical information that we have for treatment, payment, or health care operations, or to restrict the information that is provided to family, friends, and other individuals involved in their health care. But if the information is needed to provide emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide them with emergency treatment.

Our patients have a right to a restriction to disclosure of PHI to a health plan for payment if the patient has paid in full for the services and items provided in that visit.

Revisions to the Notice: OPPT reserves the right to change their terms of this Notice at any time, and the changes will be effective immediately and will apply to PHI that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our website. Our patients will be given a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints: Our patients also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services, if they believe their privacy or security rights have been violated. Complaints will not be retaliated against in any way for filing a complaint with us or to the government. Should our patients have any questions, comments, or complaints they may direct all inquiries to the Privacy Officer listed at the end of this Notice. Individuals will not be retaliated against for filing a complaint.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

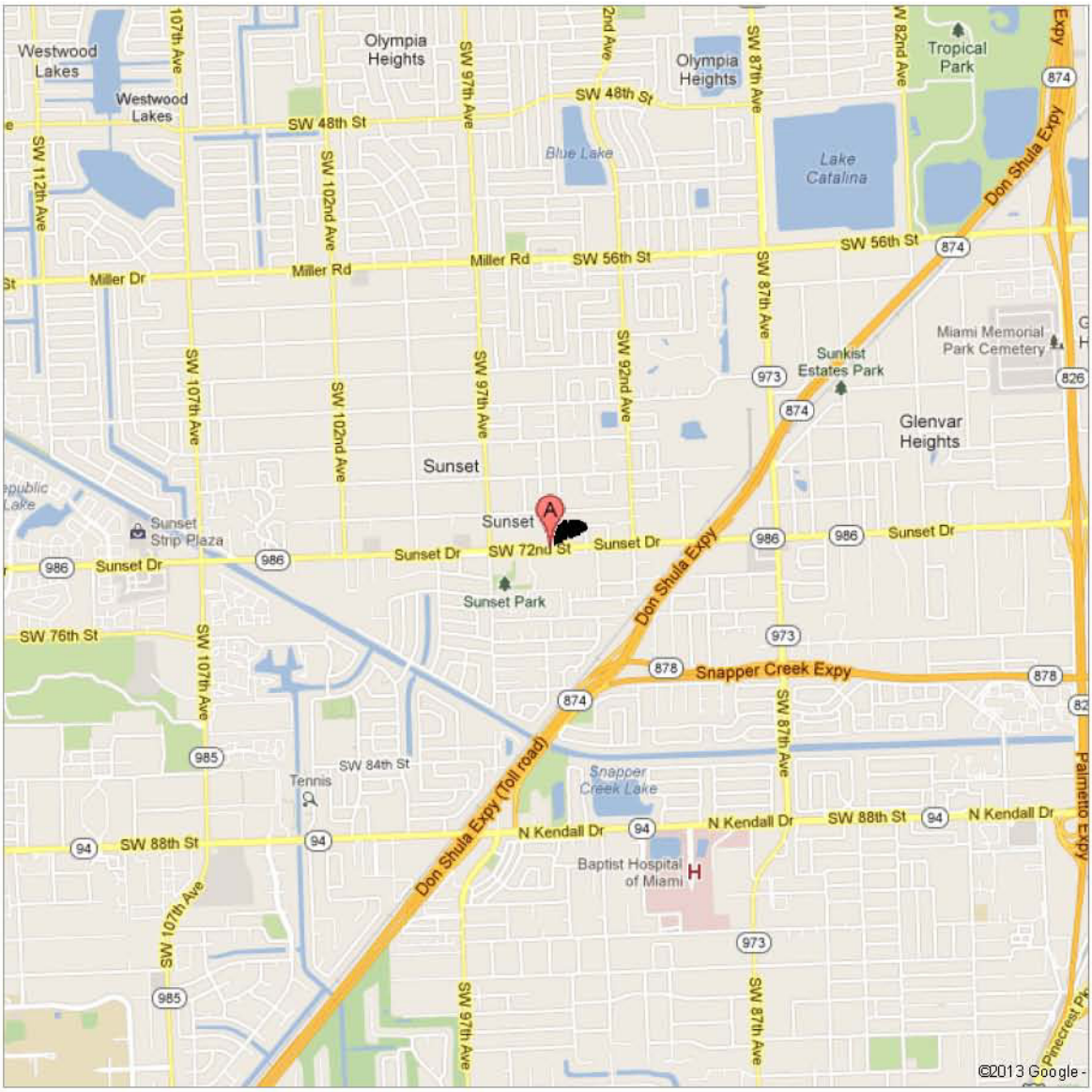
Optimal Performance and Physical Therapies
Attention: Beth Patterson Privacy Officer
3903 Northdale Blvd, Suite 111W
Tampa, FL 33624

To complain to the Secretary of Health and Human Services, please use the following information and address:
Region IV - Atlanta (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)
Roosevelt Freeman, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (800) 368-1019
FAX (404) 562-7881
TDD (800) 537-7697

This notice is effective on or after 7/18/13.

Kendall Hand and Physical Therapy Referral

Address **9415 Sunset Dr**
Miami, FL 33173



9415 Sunset Dr., Suite 111 ÅMiami, FL 33173
Phone: (786) 507-8278 • Fax: (786) 409-2692

Cancellation/No Show Policy

Kendall Hand and Physical Therapy requires a 24 hour notice for cancelling an appointment. Failure to contact our office within 24 hours of your appointment or if you no-show an appointment can result in a $45.00 charge.

This charge will not be covered by insurance. If you cancel or no-show for 3 consecutive appointments, you may be discharged from therapy and your physician will be notified.

If you are an Industrial or Work Injury Patient, your claims manager or adjuster will be notified about the missed visits.

We reserve the right to cancel or reschedule an appointment if you are more than 10 minutes late.

Thank you for your cooperation. It is our belief that this policy will help us better serve each of our patients fairly and respectfully.

_____ _____

Patient's Signature Date