OPTIMAL PERFORMANCE PHYSICAL THERAPY, LLC
5 Millbrook Road, Scarborough, ME 04074
207-510-6500
www.oppt.com

Welcome to our clinic at 5 Millbrook Road in Scarborough, ME 04074, located just off Route One, north of Scarborough Down's, south of the Maine Veterans' Home, the first house behind the C Port Credit Union. Our commitment to you is to provide the finest quality of care in a comfortable environment. Enclosed are forms we need in order to register you as our patient. Please take a few minutes to review and complete them. Don't hesitate to call us at 510-6500 or arrive 15 minutes early to your first appointment, if you need assistance with the forms.

Your first appointment is scheduled for: _____.

Future appointments will be made on your first visit. It may be helpful if you arrive with a day planner or a method of tracking your appointments so that we may best suit your schedule.

Below you will find a **"checklist"** of items you will need to have on your first visit:

1. All attached forms
2. Current insurance card
3. Secondary insurance card (when applicable)
4. Photo identification for verification of signature on file
5. Physician prescription
6. Post-surgical rehab protocol from physician and discharge summary from hospital and/or home P.T. (if you are coming to us for rehabilitation after surgery)
7. Letter of medical necessity (when applicable as required by your insurance)
8. Insurance authorization/referral as required by your insurance plan
9. Signed release(s) of information (as we cannot release any medical information without your permission
10. (Worker's Compensation) M-1 form if a worker's comp. issue

You are required to contact your insurance customer service representative to verify your benefits and eligibility for physical therapy services.

Please be sure to contact our office prior to your first visit to see that all appropriate insurance referrals and prescriptions are in place. In the absence of the appropriate referrals and prescriptions, we may need to reschedule your first appointment.

Payment is expected at the time physical therapy services are rendered. For your convenience, we accept cash, checks, or VISA and MasterCard credit and debit cards.

We look forward to working with you.

Karen Bailey, PT, ATC, IMTC, CNHP and the OPPT staff

Date:_____ Patient#:_____

PATIENT REGISTRATION

Thank you for choosing our office. In order to serve you properly, we need the following information. **PLEASE PRINT**. All information will be confidential

PERSONAL INFORMATION

Name: _____ SSN:_____ __Male __Female

Address:_____ City: _____State:_____ Zip:_____

Birth date: _____ Email Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone_____

*Patient would like to receive automatic notifications of their upcoming appointments _____ By Text _____ By Email

__Minor __Single __Married __Divorced __Widowed __Separated __Dom. Partner

Patient's employer:_____ City:_____ State: _____ Zip:_____

Spouse or Parents Name:_____ Employer_____

If patient is a student, name of school or college:_____City:_____State:_____

Whom may we thank for referring you:_____ _____

Person to contact in case of emergency:_____ Phone:_____
*Contact permitted to discuss the medical condition of the patient: _____Yes _____No

CONSENT & RELEASE

I give permission to OPPT to provide and treat my minor child or **me** with the physical therapy treatment ordered by my physician. I understand I will not be treated unless the appropriate prescription stating the diagnosis, for which I am to be treated, is obtained upon my first date of treatment. _____ Initials

I authorize release of any information concerning **my** or my child's healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to OPPT at 5 Millbrook Road, Scarborough, Maine 04074 for professional services rendered. _____ Initials

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. Any professional charges over and above the insurance payment for which I am responsible (i.e. co-payment, co-insurance, deductible, unauthorized services) I understand that payment is due at time of service. _____Initials

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my state or the above information. _____ Initials

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Patient Signature:_____ Date:_____

OPTIMAL PERFORMANCE PHYSICAL THERAPY

INSURANCE INFORMATION SHEET

In trying to be sure that we are billing correctly, we ask that you help us gather the most information about your insurance policy and your physical therapy benefits. To do this we are asking that you call your insurance company to gain answers to the following questions:

Do I have a Deductible?_____ Is that per person or family?_____
If so, what is the amount? _____
Has it been met? _____
How much have I paid toward my deductible? _____

For Physical Therapy, is there a maximum number of visits or maximum dollar amount that I am allowed per year (calendar or policy term), per diagnosis, per lifetime of the policy_____
_____

What is my benefit coverage? Insurance% _____ My% _____
Do I have a co-pay?_____ How much? _____ Every Visit? _____
Only on Evaluations or Office visits? _____

Do I have a maximum out of pocket limit? _____
How much?_____

Do I have a co-insurance?_____
How much? _____
How is that different from my co-pay? _____
_____

Do I need to get a prescription, referral, and/or authorization prior to starting Physical Therapy? _____
Do they all need to come from my primary care doctor? _____

Do I have a self-referral benefit? _____
How is it paid, what will percentage I will be responsible for? _____
Are there any limitations if I choose to self- refer?_____

FINANCIAL POLICY

Payment for services is due at the time services are rendered unless our administrator has approved payment arrangements in advance. We accept cash, checks, Mastercard, or Visa.

Returned checks are subject are subject to a $25.00 fee and balances older than 30 days may be subject to additional collection fees, court costs, legal fees and interest charges of 1-1/2 % per month. Charges will also be made for missed appointments and appointments cancelled without 24 hour advanced notice. _____ Initials

You must realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is your responsibility to understand your physical therapy benefit as provided in your insurance contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that our relationship is with you, not your insurance company. While verifying your eligibility and benefit along with the filing of insurance claims is a courtesy that we extend to our patients, eligibility and benefits are not a guarantee of payment from your insurance company. **Ultimately, all charges are your responsibility from the date the services are rendered.** Payment for services is expected at the time of service by cash, check or accepted credit cards. We realize that temporary financial problems may affect timely payment of your account. Of such problems do arise; we encourage you to contact us promptly for assistance in the management of your account.

RESPONSIBLE PARTY

Name of person responsible for this account:_____ Relationship to patient:_____

Address:_____Home Phone:_____

Birth Date:_____ SSN:_____ Driver's Lic #_____ Financial Institution_____

Employer: _____ Work Phone:_____

Is this person currently a patient at this facility _____YES _____NO

INSURANCE INFORMATION

Name of insured_____ Relationship to patient_____

Birth Date:_____SSN:_____Date employed:_____

Name of Employer:_____ Work Phone:_____

Insurance Company_____Certificate #_____Group#_____

Insurance Company Address_____City_____State_____Zip_____

PATIENT POLICIES and RESPONSIBILITIES

HIPPA Information

☐ Patient gives OPPT office the permission to leave a message on their answering machine

☐ Patient OPPT permission to discuss their medical condition with another person or people

Please list:_____

Prescription for Physical Therapy

Physical Therapists are not allowed to diagnose any patient for services rendered. The patient's medical doctor must prescribe for diagnosis. Although some insurance company's state patients may **self-refer**, physical therapy requires a prescription from your physician stating diagnosis. A **prescription** is not a **referral**. If you have any questions, we would be happy to assist you.

_____ Initials

Future Appointments/Lack of Authorization

It is the policy of this office not to schedule appointments past the point your Doctor has approved for your care. This means that when you reach the limit on treatment you doctor has approved, you will be required to obtain a new RX/insurance authorization proper to you next visit. If we do not have the appropriate paperwork at the time of the next visit, you will be required to pay for the visit in full. Any appointments cancelled due to insurance issues without 24-hour notice will be subject to our cancellation policy and applicable charges will apply. It is the responsibility of the patient to follow up.

_____Initials

Missed Appointments/Cancellation Policy

Patients may be charged $50.00 (which is not covered by insurance) for missed appointments and appointments cancelled without 24-hour notice. If a patient misses ("no shows") two appointments during the course of their treatment or cancels more than 3 appointments in a one-month period, they will be discharged from physical therapy and all future appointments shall be removed from the schedule book.

_____Initials

Changes in Insurance

As a courtesy, our office will bill the insurance company, of record for dates of service. It is vital that you inform this office of any changes pertaining to you insurance information (**e.g., Have you converted to a spouse's plan? Are you now covered by Cobra benefits? Do you have new insurance coverage?)** It is the responsibility of the patient to follow-up on any claims that were misfiled due to non-reported change in status and rebilling fees will apply.

_____Initials

Pain Scale

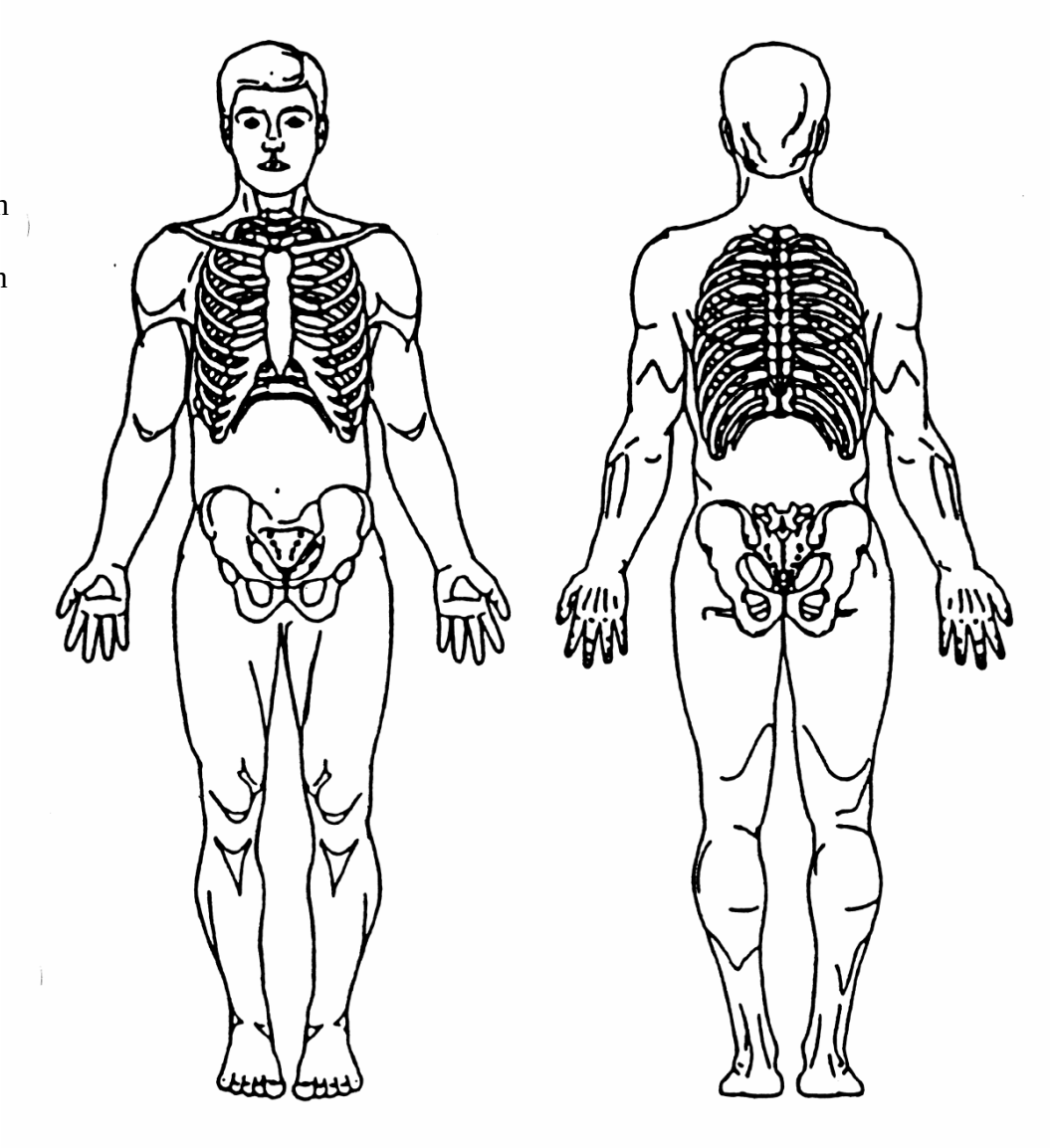
Using the symbols below, please mark on the drawing the areas where you feel pain.

≈ Numbness

◆ Severe Pain

X Moderate Pain

🡻 Shooting Pain



Please circle the number on the scale below where your pain is presently located.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain

Pain scale intensity