New Patient Intake Form

Thank you for choosing Optimum Rehab.

To help us serve you more efficiently, please read and complete each section in its entirety.
Return these completed forms via email or bring them to your first appointment.

Patient Name (Last, First, Middle Initial)	Date of Birth	Gender	
Mailing Address	City	State	Zip
Phone Number: mobile | home	Employer	Work Phone	
May we send you text reminders for your appointments? Yes | No		Social Security #	
Email	Payment Method: Insurance | Out of Pocket		
Name on Insurance Card	Insurance Provider		
Is there someone we can thank for a referral to Optimum Rehab? If yes, please list their name here:			
Emergency Contact	Phone	Relation to patient	
Primary care physician	Clinic Name		

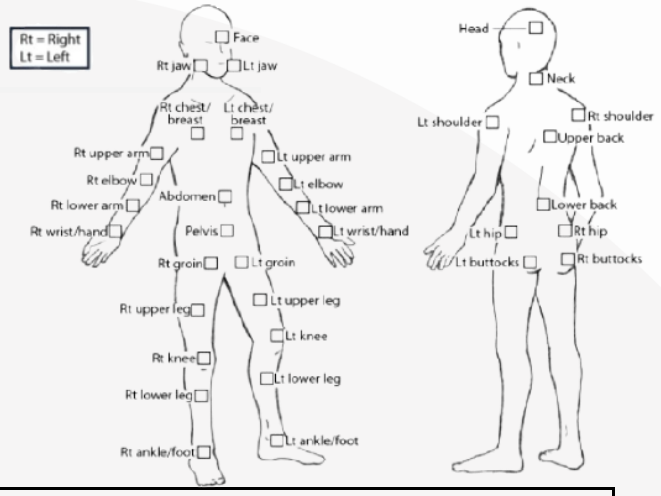
Please initial each section as appropriate	
I have received HIPAA information	
It is okay to leave messages on my voicemail and/or speak with anyone regarding my appointments via home or work phones or voicemail	

- I authorize Optimum Rehab to provide assessment and treatment for my condition.
- I assign all medical benefits to which I'm entitled to Optimum Rehab.
- I understand that co-payments are due at the time of service.
- I realize that if my insurance (third party payer) denies my charges, or makes partial payment, I am responsible for the remaining balance.
- I authorize Optimum Rehab to release all necessary information, including medical records, for safe and effective treatment of my condition and to obtain payment.

Patient Signature: _____

Parent/Guardian Signature: _____ Date: _____

What brings you to Optimum Rehab?	Date of injury/symptoms	
Date of injury/ symptoms		Please indicate areas of pain —>
What is your goal for therapy?		



Have you consulted other providers for this concern?	☐ No	☐ Yes, explain

Have you had a recent:	☐ X-ray	☐ MRI	☐ CT scan	☐ Other

Have you RECENTLY experienced any of the following? (Check all that apply)		
☐ Fatigue	☐ Fever/chills/night sweats	☐ Abdominal pain
☐ Fainting	☐ Nausea/vomiting	☐ Difficulty swallowing
☐ Dizziness	☐ Heartburn/indigestion	☐ Muscle weakness
☐ Coughing/shortness of breath	☐ Headaches	☐ Pregnancy
☐ Falls/loss of balance	☐ Bleeding/bruising easily	☐ Pacemaker
☐ Skin changes	☐ Numbness/tingling	☐ Fracture/suspected fracture
☐ Infection	☐ Weight loss	☐ Other:

Have you EVER been diagnosed with any of the following? (Check all that apply)		
☐ Cancer	☐ Multiple sclerosis	☐ Hepatitis/liver disease
☐ Depression	☐ Rheumatoid arthritis	☐ Bone or joint infection
☐ Thyroid problems	☐ Osteoarthritis	☐ Asthma
☐ Heart/cardiac problems	☐ Circulation/vascular problems	☐ STD or HIV
☐ Lung problems	☐ Epilepsy	☐ Pneumonia
☐ Diabetes ☐ Type I ☐ Type II	☐ Blood clots	☐ Spina bifida
☐ Chest pain/angina	☐ Stroke	☐ Lupus
☐ Tuberculosis	☐ Ulcers	☐ Alcoholism
☐ Osteoporosis	☐ Bladder/urinary tract infections	☐ Drug dependency
☐ High blood pressure	☐ Anemia	☐ Fibromyalgia
☐ GERD/gastrointestinal problems	☐ Kidney disease/infection	☐ Other :

Please list any surgeries/procedures you have had. Include dates.

Please sign and date		
Patient Signature	Parent and/or Guardian Signature	Date

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. (Note: this form may need to be changed to reflect the practice's particular privacy policies and/or stricter state laws.)

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect March 16, 2020 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information, we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may disclose your health information to a physician or other healthcare provided providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patient rights of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials; health information required for lawful intelligence, counterintelligence, and the other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, email, or text messages).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must request in writing to obtain access to your health information)

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Questions And Complaints:

If you want more information about our privacy practices or have questions, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information. You may complain to us, or you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S, Department of Health and Human Services upon request. We support your right to the privacy of your health information.