



Name (Print): _____
First MI Last Soc. Sec #

Address: _____
Street City State Zip

Home phone: _____ Work phone: _____ Cell phone: _____

Email Address: _____

May we contact you with clinic events, newsletters, etc.? (by e-mail): Yes No

How did you hear about Optimum Therapies: _____

Employer: _____ Years Employed: _____

Employer Address: _____

Emergency contact Name: _____ Relationship: _____

Phone Number: _____ Other Number: _____

CANCELLATION POLICY

As a courtesy to our staff and other patients we ask that you provide a **24-hour** notice if you are unable to keep your scheduled appointment.

After **3** cancel/no-show occurrences we reserve the right to review each case and determine discharge as appropriate.

Initials: _____ Date: _____

IF INJURY WAS JOB RELATED or MOTOR VEHICLE ACCIDENT, COMPLETE THIS SECTION

Is this accident related? Yes No Date of injury: _____

Type: Work Auto: State _____ Other _____ Claim # _____

Auto or Worker Comp Insurance Carrier: _____

Address of Carrier: _____
Street City State Zip

Carrier Phone: _____ Contact Person: _____

Do you have a caseworker? Yes No Caseworker Name/Phone: _____

Do you have an attorney? Yes No Attorney Name/Phone: _____

*Please read our Privacy Notice and sign this consent form.
Return all paperwork to the front desk. Thank you.

Medical History Form

Optimum Therapies, LLC

Date _____

Name: _____ DOB: _____ Age: _____

Primary Complaint: _____ Date of onset: _____

Referred by: _____ Primary MD: _____

Other clinicians you are currently seeing: _____

Date of last MD appointment: _____ Date of next MD appointment: _____

Height _____ Weight _____

Personal Medical History Have you ever been diagnosed as having any of the following conditions?

- Yes No Cancer If YES, describe what kind _____
- Yes No Heart Problems (angina/chest pain, heart attack)
- Yes No High Blood Pressure
- Yes No Circulation Problems (blood clots, peripheral vascular disease, bleeding disorder)
- Yes No Lung Problems (emphysema, COPD, asthma, shortness of breath)
- Yes No Osteoporosis
- Yes No Thyroid Problems
- Yes No Diabetes
- Yes No Multiple Sclerosis
- Yes No Rheumatoid Arthritis
- Yes No Other arthritic conditions
- Yes No Depression/Anxiety
- Yes No Hepatitis
- Yes No Tuberculosis
- Yes No Stroke
- Yes No Kidney Disease
- Yes No Anemia
- Yes No Epilepsy/Seizures
- Yes No Other

Surgical History: Please list any surgeries or other conditions for which you have been hospitalized, including date.

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

Medications: Please list any prescription and/or over-the-counter medications you are currently taking.

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____
- 7. _____ 8. _____ 9. _____

Do you have any medication or other allergies? _____

Are you latex sensitive? Yes No _____

Family History: Has anyone in your immediate family (parents, siblings) ever been treated for any of the following?

- Yes No Cancer Yes No Heart Disease
- Yes No Diabetes Yes No High Blood Pressure
- Yes No Stroke Yes No Epilepsy/Seizure Disorder

General Health

- How would you rate your health? Excellent Good Fair Poor
- Any illnesses within the last 3 months? Describe: _____ Yes No
- Do you exercise regularly? If Yes, type _____ Yes No
- Are you a past/present smoker? How much? _____ Yes No
- Females: Are you currently pregnant? Or do you think you might be? Yes No
- Do you have any implants of any kind (ex. joint, breast, pacemaker, transplant)? Yes No
- Have you had any diagnostic tests (MRI, x-ray, CT, etc.) recently? Please list _____ Yes No

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers directly to Optimum Therapies, LLC.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- I understand if payment by my insurance company is disputed or delayed, I am responsible for the payment of services rendered.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I authorize Optimum Therapies to bill my insurance carrier and receive payment directly from the insurance carrier(s).

All information provided on the patient registration form is accurate to the best of my knowledge.

Patient Name (Print): _____

Signature: _____ Date: _____

Relationship to Patient: _____

**For further information, or to file a complaint with no retaliation from this facility, please contact our office manager.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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