OPTA
ORTHOPAEDIC PHYSICAL THERAPY ASSOCIATES

1068 Main Street, Suite A, Sanford, Maine 04073 (207) 324-6789 fax: (844) 292-4021
23 Hannaford Drive, Scarborough, Maine 04074 (207) 883-6789 fax: (844) 292-4021

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Summary of Rights and Obligations Concerning Health Information

Orthopaedic Physical Therapy Associates is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices; with respect to using and disclosing your health information that is created or retained by Orthopaedic Physical Therapy Associates. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, as well as a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

Although your health record belongs to Orthopaedic Physical Therapy Associates, the information in your record belongs to you. You have the right to:

- ensure the accuracy of your health record;
- request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
- request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- maintain the privacy of your health information;
- provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of our most current *Notice of Privacy Practices*;
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Please refer to the "Notice of Privacy Practices" for a full description of how medical information about you may be used and disclosed as well as how you may access this information.

I acknowledge that I have been provided an opportunity to read and/or receive a copy of the Notice of Privacy Practices.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Signature of Provider Representative/Authorized Representative

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Payment Agreement

Thank you for choosing Orthopaedic Physical Therapy Associates LLC (OPTA) as your rehab provider. To receive services from us, you agree to the following Payment Policies:

- **Payment Terms.** You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved. Payment for copays, coinsurance and deductibles is expected at the time of service or within 30 days of receiving our bill unless you have made other payment arrangements with us.
- **Medicare.** If you have Medicare and your services are medically necessary covered benefits, we will bill Medicare or your Medicare Advantage Plan on your behalf. You will only be responsible for your co-insurance or co-pay portion of the visit. If at any time we believe your services might not be covered by Medicare, we will discuss this with you and have you sign an "Advanced Beneficiary Notice" indicating whether you want to receive and pay for the services yourself if Medicare doesn't pay.
- **In-Network Claims**. If we are in-network with your health plan, we will submit the claims to your health plan on your behalf and your health plan will send payment directly to us. If your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless of whether you have filed or plan to file an appeal. You hereby assign and convey directly to OPTA all health plan benefits and/or insurance reimbursement benefits otherwise payable to us for medical services, treatments, therapies and/or examinations rendered or provided by us. You authorize Provider to release all medical information necessary to process my claims to the responsible Payor. You also agree that if any payments are sent to you despite your assignment of benefits to us, you will promptly forward the funds and explanation of benefits/payment to Provider.
- **Out-of-Network Claims.** If we are out-of-network, payment is expected in full at the time of service unless you have made other payment arrangements with us. We may, at our sole discretion, agree to set you up a payment plan or make other payment arrangements. We will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. We may agree to bill your health plan for our services directly and await payment from your health plan if you execute the assignment of benefits agreement below. You agree that if your health plan does not honor the assignment and sends payment to you, you will promptly forward the payments to us. You further agree that if your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless of whether you have filed or plan to file an appeal.
- **Cash Payment Policy.** We offer a discounted cash payment rate when patients pay cash at the time of service in exchange for the prompt payment and the reduction in administrative work/time since we don't have to file claims or obtain pre-authorization. This cash payment discount is offered to patients who do not have insurance or who choose <u>not</u> to use their health plan benefits. If we are in-network with your health plan, our cash payment rate *may* be less than the in-network rate that we have negotiated with your health plan. *If you choose to take advantage of our discounted cash payment policy, you understand that we will not submit a claim to your health plan and agree that you will not submit our claims or statements to your health plan in an attempt to get reimbursed for our services.* If you choose to pay cash initially and later want to switch to using your health plan, you understand that the fees for our services may be higher and you will no longer be entitled to our discounted cash price. Your ability to switch to using your health plan benefits may also be limited by your health plan's requirements for pre-authorization or other policy limitations.

- **Workers' Compensation.** If your injury is work-related, we will bill your company's workers' compensation carrier if you have filed an injury report with your employer and your right to workers' compensation benefits is not in dispute. If you are informed that a dispute about your right to workers' compensation benefits has arisen after you have begun treatment with us, you agree to inform us immediately. You will have a choice at that time to pay for your treatment out of pocket or allow us to bill your health insurance. In the event you do not have health insurance and cannot pay privately, we will discuss your options with you at that time.
- **Auto or other Liability Insurance.** If you have been involved in a motor vehicle accident, you can choose to use your MedPay benefits (up to the limit in your policy) or your health plan benefits. If you choose to use your health plan benefits, you should know that most health plans limit coverage for therapy to a certain number of visits per year. If you use your visits for your auto injury, you may not have visits available for other therapy needs throughout the year. Therefore, you should consider using your MedPay benefits under your auto insurance policy first so you don't exhaust your health plan benefits. If you choose to use your MedPay benefits, you will pay us at the time of service and we will give you a copy of your bill that you can submit to your auto insurer for reimbursement. If you choose to bill your health plan, you will be responsible for all copays, coinsurance and deductibles. If your health plan limits your therapy benefits, you will also be responsible for your full bill once you reach any limitations/exclusions. If you do not have health insurance or you exhaust your health and/or MedPay benefits, we may, at our discretion, agree to await payment when your case settles. If we do, you agree to give us a lien on any settlement, judgment or insurance proceeds you receive for payment of any and all unpaid claims, including late payment interest, and authorize your attorney to pay us out of the settlement/verdict proceeds. You understand that we are not obligated to discount any portion of our service or late payment penalty fees when your case settles regardless of the amount of your settlement or whether your settlement adequately covers your balance due to us.
- **Late Payment Penalty.** A late payment penalty in the amount of 18% on unpaid claims will be added every month that your claims go unpaid after you are discharged from our care. You agree to be personally responsible for paying such penalties unless applicable law requires your health plan or other responsible Payor to pay it.
- **Appeals**. You understand that you are responsible for filing all appeals of adverse benefit determinations. We may be willing to file appeals on your behalf if you appoint us as your Authorized Representative (see below). By appointing us as your Authorized Representative, we are given the right by you to (1) obtain information regarding the claim to the same extent as you; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator. Our acceptance of the appointment as your Authorized Representative is no guarantee that your claims will be paid or alter your ultimate responsibility to pay our claims.
- **Collection Actions.** You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Signature of Provider Representative/Authorized Representative

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Assignment of Benefits and Authorized Representative Appointment

Assignment of Benefits

_____ (Initial) By initialing, I hereby assign and convey directly to Orthopaedic Physical Therapy Associates LLC (OPTA) all health plan benefits and/or insurance reimbursement benefits (including MedPay and/or Personal Injury Protection benefits), if any, otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by Provider regardless of its managed care network participation status. I hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor. I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.

Appointment of Authorized Representative

_____ (Initial) By initialing, I hereby appoint OPTA (hereinafter "Provider") as my designated Authorized Representative to act on my behalf in the filing or pursuance of claims and appeals with my health plan, auto liability insurance plan or other liable Payor or Payors in connection with medical services, treatments, therapies and/or examinations rendered or provided by OPTA regardless of its managed care network participation status. I understand that as a result of this authorization, the Payor(s), plan administrator, fiduciary, insurer and/or attorney may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care claims to the Provider. Further, I hereby authorize my health plan, plan administrator, fiduciary, insurer, and/or attorney to release to Provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon request from Provider or its attorneys in order to claim such medical benefits. As my Authorized Representative, Provider is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator. Provider, as my Authorized Representative, Provider may also bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Provider's expense. This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

Right to Revoke Designation and/or Assignment

I acknowledge that Provider has not made the provision of my medical care contingent upon this designation of Provider as Authorized Representative. I understand that I may revoke this Authorized Representative appointment at any time by giving written notice to Provider and Payor(s) except to the extent that any party has taken action in reliance on this appointment before they knew of the revocation. I further understand that revocation of Provider as my Authorized Representative does not release me from my obligation to pay Provider's claims. Unless revoked, this Authorized Representative appointment is valid for all administrative and judicial reviews under the Affordable Care Act, ERISA, Medicare and applicable federal and state laws until Provider's claims are paid in full. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____
Signature of Patient and/or Guardian

X_____ Date: _____
Signature of Provider Representative/Authorized Representative

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CONSENT FOR PHYSICAL THERAPY EXAMINATION AND TREATMENT

1. I hereby authorize the therapists of Orthopaedic Physical Therapy Associates and/or such associates and assistants as may be selected to perform physical therapy procedures as are considered necessary.
2. I have been informed to my satisfaction and understanding by the physical therapist of the following: (1) the general nature of the ailment; (2) the general nature of the recommended or contemplated procedures to correct or evaluate the ailment; (3) the recognized risks of serious harm and complications as well as consequences pertinent to my decision to accept or reject the recommended treatment; (4) the expected benefits and goals associated with the recommended treatment and the prospects of success; and (5) the reasonable alternatives to the proposed treatment as well as those risks and benefits.
3. I am aware that the practice of physical therapy is not an exact science and that unexpected complications may occur. I acknowledge that no guarantees have been made to me concerning the outcome or procedures.
4. This consent form has been fully explained to me in laymen's terms, and I certify that I understand its contents; all questions which I have raised have been fully answered.

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Consent for Email Communication

Patients/Clients frequently request that we communicate with them by email. Orthopaedic Physical Therapy Associates respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email can be inherently insecure as a method of communication, we will only communicate with you by email with your written consent at the email address you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email you are consenting to email communications that may not be encrypted. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through email. Orthopaedic Physical Therapy Associates will not be responsible for any privacy or security breaches that may occur through email communications that you have consented to.

You may choose to limit the type of email communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email.

*please initial one of the following consents:

____ (Initial) I consent to receiving email communication about the scheduling of appointments and other communications that do not reveal my protected health information.

____ (Initial) I consent to all communication by email, including but not limited to communication about my medical condition and advice from my health care providers.

E-mail address you are consenting to communicate through: _____

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____
Signature of Patient and/or Guardian

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PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ AGE: _____ DATE: _____

MAILING ADDRESS: _____
STREET CITY STATE ZIP

HOME ADDRESS (IF DIFFERENT FROM ABOVE): _____

SOCIAL SECURITY: _____ PHONE 1: _____ (M / H) PHONE 2: _____ (M / H)

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____
STREET CITY STATE ZIP

WORK PHONE: _____ EXT: _____

SPOUSE (PARENT): _____ BIRTH DATE: _____ SOCIAL SECURITY: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____
STREET CITY STATE ZIP

WORK PHONE: _____ EXT: _____

EMERGENCY CONTACT: _____ PHONE: _____

What is the date of your next scheduled visit with your referring physician? _____ Time? _____

May we add you to our e-mail mailing list to receive newsletters or other pertinent material that you may find helpful?

If so, please provide your e-mail address: _____

INSURANCE INFORMATION

WORK RELATED: YES/NO ACCIDENT RELATED: AUTO/OTHER STATE OF ACCIDENT _____

IF YES, **DATE OF INCIDENT**: _____ CLAIM NUMBER: _____

ATTORNEY: _____ PHONE: _____ EXT: _____

ADDRESS: _____
STREET CITY STATE ZIP

PRIMARY INSURANCE: _____ GROUP NO. _____ ID NO. _____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ EXT: _____ CONTACT PERSON: _____

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE: _____ GROUP NO. _____ ID NO. _____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ EXT: _____ CONTACT PERSON: _____

NAME OF INSURED: _____ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

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PERSONAL & FAMILY MEDICAL HISTORY

Name:	**DOB:**	**Today's Date:**

Medical Testing

Please list the **Name** of any **prescription and over-the-counter medications** that you are currently taking.

Medication	Dosage	Frequency	Route (oral, topical, injection)

Please list any **radiographs (x-rays), computed tomography scans (CT), magnetic resonance imaging (MRI), sonograms**, **and bone scans** you have had in the past 12 months.

Date	Where	Test Results

Please list any **laboratory work (urinalysis, blood tests or other)** that you have had in the past 12 months.

Date	Where	Test Results

Please list any **operations** that you have ever had.

Date	Where	Procedure

Name:	DOB:	Today's Date:

General Health

	Circle One	
Have you had any illnesses within the last 3 weeks (fever, cold, influenza, and bladder or kidney infection)?	Yes	No
Have you noticed any lumps or thickening of skin or muscle anywhere on your body?	Yes	No
Do you have any warts, moles or sores that have changed in size, shape or color or have not healed?	Yes	No
Have you had any unexplained weight gain or loss in the last month?	Yes	No
Have you had any fever, chills or night sweats?	Yes	No
Have you had any recent alteration in bowel or bladder habits, trouble initiating urination, change in urinary frequency or loss of control of your bowels or bladder?	Yes	No
Have you had any recent headaches, nausea, vomiting, or ringing in your ears?	Yes	No
Have you had any recent light headedness, dizziness, sensation that you may faint or actual loss of consciousness?	Yes	No
Have you had any recent weakness or sense of fatigue?	Yes	No
Is there any chance you may be pregnant?	Yes	No
Do you or have you ever smoked or chewed tobacco?	Yes	No
If yes, how many packs/day?		
How many months or years?		
When did you quit?		
How much alcohol do you drink in the course of a week?		
How much caffeine do you consume daily (including soft drinks, coffee, tea, or chocolate)?		
Are you on any special diet prescribed by a physician?	Yes	No
Do you have a pacemaker, transplanted organ, or metal implants (including joint replacement or IUD)?	Yes	No

Work Environment

Occupation:

Does your job involve the following:	Circle One	
Prolonged sitting (e.g., desk, computer, driving)	Yes	No
Prolonged standing (e.g., equipment operator, sales clerk)	Yes	No
Prolonged walking (e.g., mill worker, delivery service)	Yes	No
Use of large or small equipment (e.g., fork lift, drill press, typewriter, telephone, cash register)	Yes	No
Lifting, bending, twisting, climbing, turning	Yes	No
Exposure to chemicals, pesticides, toxins	Yes	No

Other, please describe:

Do you use any special supports:	Circle One	
Back cushion, neck cushion	Yes	No
Back brace, corset	Yes	No
Other kind of brace or support for any body part	Yes	No

Other, please describe:

Other

History of falls:

Fall — A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Have you lost your balance, stumbled or tripped with or without falling or catching yourself before falling?	Yes	No
Did you suffer any injury or seek treatment after falling?	Yes	No
How many times have you lost your balance, stumbled or tripped in the last year?		

Name:	DOB:	Today's Date:

Past Medical History

Have you or any one in your immediate family (parents, brother, sister) ever been diagnosed with or treated for any of the following:			**NOTES**:
CHECK ONE:	Self	Family	
Heart disease/arrhythmia			
Angina or chest pain			
Hypertension or high blood pressure			
Hypoglycemia			
Shortness of breath			
Asthma			
Allergies, hay fever			
Chronic bronchitis			
Emphysema			
Pneumonia			
Tuberculosis			
Diabetes			
Cancer			
Thyroid problems			
Anemia			
Hemophilia/slow healing			
AIDS/HIV-positive			
Kidney disease/stones			
Cirrhosis/liver disease			
Hepatitis/jaundice			
Urinary tract infection			
Rheumatic fever/scarlet fever			
Ulcers/stomach problems			
Arthritis/gout			
Osteoporosis/Low bone density			
Rheumatoid Arthritis			
Fibromyalgia/myofascial pain syndrome			
Migraine headaches			
Stroke			
Seizures/Epilepsy			
Multiple sclerosis			
Polio			
Guillain-Barre syndrome			
Other (please describe)			