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.

_____ _____

Signature Date

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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)			

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Payment Agreement

Thank you for choosing Orthopaedic Physical Therapy Associates as your physical therapy provider. To receive services from us, you agree to the following Payment Policies:

- 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 is expected in full at the time of service or within 30 days after receiving our bill unless you have made other payment arrangements with us.
- Interest in the amount of 1 1/2% per month (18% annual interest rate per year) may be added to your bill for any and all claims that are not paid within thirty (30) days of the invoice or statement date. You agree to be personally responsible for paying such interest unless the responsible Payor is required to pay such interest under federal, state or other applicable laws.
- 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 whether you have filed or plan to file an appeal. You hereby assign and convey directly to Orthopaedic Physical Therapy Associates all health plan benefits and/or insurance reimbursement benefits otherwise payable to you for medical services, treatments, therapies and/or examinations rendered or provided by us. You authorize Provider to release all medical information necessary to process your claims to the responsible Payor. You also hereby 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.
- 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 whether you have filed or plan to file an appeal. We may, at our sole discretion, agree to bill your health plan directly if you assign your benefits to us by executing a separate Assignment of Benefits Agreement that we will provide.
- If your injury is **work-related**, we will bill your company's workers' compensation carrier if and only 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.

- If an **auto or other liability** insurer is be responsible for paying your claims, you hereby assign your MedPay or other applicable benefits to us for the payment of our claims. You further 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. In the event your auto insurer or other liable party denies our claims or refuses to honor the assignment, we may, at our sole discretion, bill your health plan. If we do, you will be responsible for refunding any fees owed to your health plan when you settle your case. We may also, at our discretion, agree to wait until your case settles before requiring payment. If we do, you understand that we are not obligated to discount any portion of our service or interest fees when your case settles regardless of the amount of your settlement or whether your settlement adequately covers your balance due to us.
- You understand that you are responsible for filing all appeals of adverse benefit determinations. We are 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.
- 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/Witness

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Assignment of Benefits and Authorized Representative Appointment

- ☐ **Assignment of Benefits**. I hereby assign and convey directly to Orthopaedic Physical Therapy Associates 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.** By checking this box, I hereby appoint
  - ☐ Kenneth N. Simons, PT, DPT, MS, OCS
  - ☐ M. Nicholas Burns, PT, DPT, MS, OCS

  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 Orthopaedic Physical Therapy Associates 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