Omni Physical Therapy

Your All Inclusive Manual Therapy Provider

Client Intake Form

Name: _____ Date: _____

SSN: _____ Date of Birth: _____

If minor: Parent / Guardian: _____

Parent SSN: _____ Parent DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #_____ Email Address: _____

Sex: ❑ Male ❑ Female:

Are you comfortable being treated by a staff member of the opposite gender? ❑ Yes ❑ No

Employer: _____

Occupation: _____

Employer's Address: _____

Type and location of injury_____ Date of Injury_____

Return date to doctor: _____ Marital status: ❑ Single ❑ Married

Referring Doctor: _____Phone: _____Fax: _____

Primary Health Care Doctor: _____Phone: _____Fax: _____

Permission to Consult with Primary Doctor? ❑ No ❑ Yes _____ (please initial if yes)

In Case of Emergency, Please Notify: Name: _____

Telephone #: _____ Relationship: _____

How did you hear about Omni Physical Therapy?

❑ Physician ❑ Family/Friend ❑ Advertisement/Online ❑ Insurance

By my signature below, I authorize OMNI PHYSICAL THERAPY LLC. to treat me. I understand I have the right to refuse this treatment. All medical expenses shall be my responsibility. I agree to pay any additional charges related to the cost of collection (including but not limited to finance charges, interest, collection agency fees, reasonable attorney's fees and court costs). I authorize ASAPC to release any medical information necessary for the processing and payment of my bills to any insurance company or other third-party payer who is or may be responsible for paying for medical treatment. I further authorize release of copies to the referring physician or physicians consulted in regard to said treatment. I further authorize the use of said records for the purpose of Workmen's Compensation disclosure. I hereby assign, transfer, and set over to Omni Physical Therapy LLC all of my rights, title and interest to my medical reimbursement benefit under my insurance policy.

SIGNATURE: _____ **Witness** _____ **Date**_____

Patient or parent/guardian of minor child

1000 Des Peres Road, Suite 130 Des Peres, MO 63131 Office (314) 775-0183 Fax (314) 775-0190

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Informed Consent

I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

I am informed and fully understand that there are certain risks in any physical therapy treatment. These risks include but are not limited to: post-treatment soreness, tenderness, or sensitivity within muscles and/or joints, complications from home exercises and/or treatments including traction, ultrasound, and electrical stimulation provided by Omni Physical Therapy.

A more complete explanation of all complications is available to me upon my request from my Physical Therapist.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of physical therapy is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of my treatment.

SIGNATURE: _____ **Witness** _____ **Date**_____

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IMPORTANT: RELEASE AND WAIVER OF LIABILITY AND INDEMNITY. You acknowledge that I take full responsibility for all activities in which I participate at Omni Physical Therapy LLC. I hereby acknowledge and agree that use of Omni Physical Therapy LLC facilities, services, equipment or premises involves risks of injury to persons and I assume full responsibility for such risks. I hereby release and hold Omni Physical Therapy LLC free from all liability for any loss or damage, and forever give up any claim or demands therefore, on account of injury to person or property, including injury leading to the death, whether caused by the active or passive negligence of Omni Physical Therapy LLC or otherwise, to the fullest extent permitted by law, while upon, or about Omni Physical Therapy LLC premises or using any Omni Physical Therapy LLC facilities, services or equipment. By signing above, I acknowledge that I have read and understand this Waiver of Liability.

Cancellation Policy

At Omni Physical Therapy, we do our best to schedule patients as soon as possible and according to each patient's personal needs and availability. We ask that you contact our office **24 hours** in advance if you need to cancel an appointment so we have the opportunity to offer your appointment to another patient.

- We require a **24 hour** advanced notice for cancellations of an appointment to avoid a **$45** cancellation fee.
- If you do not show up for a scheduled appointment, you will be charged a **$45** no show fee.
- Three consecutive cancellations or missed appointments may result in discharge from physical therapy

I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no shows.

SIGNATURE: _____ **Witness** _____ **Date**_____

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NOTICE OF PRIVACY

The staff of Omni Physical Therapy LLC has always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your health information without your consent. Now state and federal laws also attempt to ensure the confidentiality of this sensitive information.

This Notice of Privacy will inform you of our privacy practices and your rights. Our practices and your rights are as follows.

1. All staff have been trained to maintain confidentiality of your medical records.
2. If you are a parent or guardian of a minor, you have a right to the health record of the minor.
3. You have the right to limit who among family has access to your record by telling us who can receive such information by filling out the section below for this purpose. In the event that you choose not to limit access by family, leave the section below blank.
4. The law allows us to use your patient information for treatment, payment and administrative proposes without your written consent.
5. You have a right to your medical record at any time by filling out a form available from the receptionist. It is customary that a nominal fee be assesses for copying services.
6. The law does allow treating staff to discuss your treatment without your consent.
7. Your record is safeguarded from exposure to casual workers entering the office such as delivery and service personnel.
8. We will make every effort to ensure a confidential space for sensitive conversations between you and our staff.

These rules are to ensure your privacy while under our care. If you have any questions, concerns, or comments about this Notice of Privacy, please contact: Hunter Knight, PT, our designated privacy officer, at 314-775-0183.
I have read and understand the above statements and I authorize release of my medical record to any of my immediate family.

SIGNATURE: _____ **Date**_____

Patient or parent/guardian of minor child

Limited Family Access to the Medical Records

I want to exercise my right to limit access to my medical records by my family. Listed below are the family members I want to have access to my medical record:

_____ _____

_____ _____

SIGNATURE: _____ **Date**_____

Patient or parent/guardian of minor child

NO Family Access to the Medical Records

I do not want any of my family to have access to my medical record.

SIGNATURE: _____ **Date**_____

Patient or parent/guardian of minor child

Omni Physical Therapy LLC. will be happy to comply with your request. This document will be made a part of your permanent record unless you give us different instructions

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FINANCIAL POLICY

Thank you for choosing Omni Physical Therapy LLC (Omni PT) as your provider for rehabilitation. We appreciate the opportunity to serve you. As part of our service, we try to contain the ever-rising cost of healthcare. To do this, we have implemented our financial policy. The following statements will explain the reimbursement process and outline your financial responsibility.

FILING INSURANCE

Our office will submit all insurance claims; however, co-payments, co-insurance and unmet deductibles must be paid at the time of service. At Omni Physical Therapy, we will bill your insurance carrier solely as a courtesy to you. Filing your insurance is a service we provide, however, it does not relieve your from the responsibility for any outstanding balance. We require that arrangements for payment of your estimated share be made today. If insurance payment is not received within 60 days, we reserve the right to transfer the unpaid balance to the patient for full and prompt payment. Should we exercise this right, payment can be made by cash, check, or credit card. If necessary, a payment plan may be established. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Omni Physical Therapy.

We make a call to each patient's insurance plan prior to the initiation of physical therapy in an attempt to clearly identify each patient's responsibility per their insurance plan, but we are limited by the information provided by the insurance representatives as well as the insurance policy provisions. In the event that your insurance company mis-quotes your benefit plan to us; this does not release you from your financial responsibility to Omni Physical Therapy. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

NON-COVERED SERVICES

Each insurance policy may contain clauses that prohibit payment for a particular service. This does not mean it is not a medically appropriate service. It simply means that this policy does not cover a particular service. Such services are the responsibility of the patient. Also, some supplies needed for your home program may not be covered by your insurance. You will be advised of any such items and payment is expected at the time you receive such a supply item.

USUAL & CUSTOMARY RATES

Every insurance company uses a table of what it considers "usual & customary rates (UCR)". These rates are established using a wide geographic area and may not truly represent reasonable rates for this area. Any "UCR" reduction taken by your insurance will shift the responsibility for this charge to that of the patient.

WORKERS' COMPENSATION

Omni Physical Therapy LLC. will accept claims and provide treatment to patients who contend that their employer is responsible for an injury. All such claims will be verified with the employer and the Workers' Compensation Insurance Provider within 48 hours. If, at any point, the Workers' Compensation Claim is denied, the claim becomes the full responsibility of the patient. In this event, Omni Physical Therapy LLC reserves the right to either bill the patient's medical insurance or establish a cash payment plan with the patient.

AUTOMOBILE ACCIDENTS / LITIGATION / LIABILITY CLAIMS

Omni Physical Therapy LLC. will accept such claims, provided:

1. Omni Physical Therapy LLC will bill through your medical insurance, all co-pays and co-insurances will be paid before each treatment.
2. Any remaining balance is the responsibility of the patient / guardian.

STATEMENTS

Should you have any questions regarding a bill, you may contact Omni Physical Therapy LLC. at 314-775-0183. If Omni Physical Therapy LLC. is a participating provider in your insurance plan, you will not receive a statement until your insurance plan has paid its full portion of your claim. After that point, you will receive a monthly statement to settle your portion of the bill. The balance on your statement is due and payable upon receipt, and is past due if not paid within 30 days. If you cannot pay the balance in full, please contact our office immediately so that we may make arrangements for payment. If your account becomes past due and arrangements for payment have not been made, we will take necessary steps to collect this debt. If necessary, the collection of debt could include the use of a collection agency. Please note, if a check is returned to us, there will be a $25.00 service charge that must be reimbursed by the patient to Omni Physical Therapy.

By signing below, I verify that I have read and agree to the above Financial Policy.
A parent/guardian must sign if the patient is age 17 or younger.

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PAST MEDICAL HISTORY

Musculo-Skeletal
- □ Headaches
- □ Joint stiffness/swelling
- □ Spasms/cramps
- □ Broken/fractured bones
- □ Strains/sprains
- □ Back, hip pain
- □ Shoulder, neck, arm, hand pain
- □ Leg, foot pain
- □ Chest, ribs, abdominal pain
- □ Problems walking
- □ Jaw pain/TMJ
- □ Tendonitis
- □ Bursitis
- □ Arthritis
- □ Osteoporosis
- □ Scoliosis
- □ Bone or joint disease
- □ Other: _____
- □

Circulatory and Respiratory
- □ Dizziness
- □ Shortness of breath
- □ Fainting
- □ Cold feet or hands
- □ Cold sweats
- □ Swollen ankles
- □ Pressure sores
- □ Varicose veins
- □ Blood clots
- □ Stroke
- □ Heart condition
- □ Allergies
- □ Sinus problems
- □ Asthma
- □ High blood pressure
- □ Low blood pressure
- □ Lymphedema
- □ Other: _____

Skin
- □ Rashes
- □ Allergies
- □ Athlete's Foot
- □ Warts
- □ Moles
- □ Acne
- □ Cosmetic surgery
- □ Other: _____
- □

Digestive
- □ Nervous stomach
- □ Indigestion
- □ Constipation
- □ Intestinal gas/bloating
- □ Diarrhea
- □ Diverticulitis
- □ Irritable bowel syndrome
- □ Crohn's Disease
- □ Colitis
- □ Adaptive aids
- □ Other: _____
- □

Nervous System
- □ Numbness/tingling
- □ Twitching of face
- □ Fatigue
- □ Chronic pain
- □ Sleep disorders
- □ Ulcers
- □ Paralysis
- □ Herpes/shingles
- □ Cerebral Palsy
- □ Epilepsy
- □ Chronic Fatigue Syndrome
- □ Multiple Sclerosis
- □ Muscular Dystrophy
- □ Parkinson's disease
- □ Spinal cord injury
- □ Other: _____

Reproductive System
- □ Pregnancy:
- □ Current
- □ Previous
- □ PMS
- □ Menopause
- □ Pelvic Inflammatory Dis
- □ Endometriosis
- □ Hysterectomy
- □ Fertility concerns
- □ Prostate problems
- □ Other
- □ Loss of appetite
- □ Forgetfulness
- □ Confusion
- □ Depression
- □ Difficulty concentrating
- □ Drug use _____
- □ Alcohol use _____
- □ Nicotine use _____
- □ Caffeine use _____
- □ Hearing impaired
- □ Visually impaired
- □ Burning upon urination
- □ Bladder infection
- □ Eating disorder
- □ Diabetes
- □ Fibromyalgia
- □ Post/Polio Syndrome
- □ Cancer
- □ Infectious disease (please list) _____
- □ Congenital or acquired disabilities (please list) _____
- □ _____
- □ Surgeries_____
- □ Other: _____
- □ Medications

_____
_____
_____
_____

I agree to take an active role in my Physical Therapy treatment.

SIGNATURE: _____ **Date**_____

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