Optimal Life Therapy and Wellness, LLC
Phone: (859) 331-0474
220 Thomas More Pkwy Crestview Hills, KY 41017

www.optlifetherapy.com
Email: mandy@optlifetherapy.com
Jordan@optlifetherapy.com

Patient Information

Thank you for choosing Optimal Life Therapy and Wellness as your provider. Please fill out the information below to better help serve you. All information will be kept strictly confidential.

<table>
<tr><td colspan="2">Last name: First Name: M.I.</td><td>Gender:</td><td>DOB:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="2">City/ Zip:</td><td>State</td><td>Phone (H)
(mobile)</td></tr>
<tr><td colspan="4">Email:</td></tr>
<tr><td colspan="2">Emergency Contact:
Name:

Phone:

Relationship</td><td colspan="2">How would you like to be contacted:
❏ Home Phone
☐ Cell Phone
❏ Email</td></tr>
<tr><td colspan="2">PrimaryInsurance:
Group #:
ID #:</td><td colspan="2">Secondary Insurance:
Group #:
ID #:</td></tr>
<tr><td colspan="4">Primary Care Physician:
Address:
Phone:</td></tr>
<tr><td colspan="4">How did you hear about Optimal Life Therapy and Wellness?</td></tr>
<tr><td colspan="4">Have you had any Outpatient Physical Therapy this year?</td></tr>
</table>

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Patient Rights and Responsibilities:

I acknowledge that I have received and reviewed a copy of my **Patient Responsibilities** and **Patient Rights** as a client or patient of Optimal Life Therapy and Wellness. Optimal Life Therapy and Wellness reserves the right to change the **Patient Responsibilities** and **Patient Rights** and I reserve the right to request a copy of the updated version upon request.

initial

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received and reviewed a copy of the Optimal Life Therapy and Wellness **Notice of Privacy Practices**. Optimal Life Therapy and Wellness reserves the right to revise the Privacy Practices at any time. A copy may be obtained by verbal or written request from Amanda Smith, PT at 220 Thomas More Pkwy. Crestview Hills, KY 41017.

initial

Consent for Use and Disclosure of Protected Health Information

I give my consent for Optimal Life Therapy and Wellness, LLC to: (mark all that apply)

- ❑ Leave a message on Voicemail pertaining to appointment reminders
- ❑ Receive text messages regarding appointments
- ❑ Mail patient statements or other required paperwork to the address listed by patient/client

We may only disclose necessary information regarding your health with your physicians, insurance (for billing purposes) and individuals listed below.

Name/Relationship

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Privacy Practices

Notices of Privacy Practices for Protected Health Information

This Notice describes how Medication information about you may be used and disclosed and How you can access the information. Please review carefully.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Its purpose is to describe your legal rights and how Optimal Life Home Therapy may use and disclose your Protected Health Information (PHI). Optimal Life Home Therapy creates a detailed record of care and services to provide you with quality care and comply with legal requirements. We are required by law to protect your health information.

Uses and disclosure of PHI by Patient consent

- We may use PHI to provide you with appropriate health care treatments/services . This includes but is not limited to discussions with referring physicians to plan care and treatments.
- We may use and disclose PHI to third party or insurance companies to obtain benefit information and prior approval for treatment or justify care
- We may use and disclose PHI to ensure that you are receiving the highest quality of care

Uses and Disclosures of PHI as required by Law

We will disclose PHI when required to do so by federal, state, or local law.

- To avert serious health injury or safety
- For military personnel or veteran dept
- Public health risks
- In response to subpoena or other lawful requests
- Coroner or health examiner
- National security or Intelligence Agencies,

Your Rights as a Patient to your PHI

You have a right to the following:

- To inspect and/or copy your medical records
- To request an amendment to your records
- To request restriction, limitation or confidentiality of your PHI
- To obtain a copy at any time.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary of Department of Health and Human Services at 1-800-368-1019 or email:OCRMail@hhs.gov

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Financial Policy

It is important that you understand your financial responsibility before treatment begins. You are responsible for the timely payment of charges. Please read the following form. We would be happy to answer any questions you may have.

Medicare: As a participating Medicare provider, we will file your claims. Medicare has a yearly deductible of $240 for the year 2024. You are responsible for:

1. Any of your yearly deductible met by Optimal Life Therapy and Wellness
2. The 20% portion not covered by Medicare (if your secondary insurance is not a Medigap or automatic crossover)
3. Any supplies purchased.

- There is a Medicare Fee Threshold of $2,330 for calendar year 2024.
- A physician's Signed Plan of Care is required to bill Medicare

Private Insurance: Optimal Life Therapy and Wellness is currently in-network with most Anthem BCBS. We CAN accept other private insurance plans as an OUT-OF-NETWORK provider.

Co-Pays: The patient/client is responsible for ALL co-pays on the day of the visit if applicable to your plan. You will be notified if you have a co-pay on your initial visit.
Liability/Auto/Worker's comp: We do not accept Auto, Liability, or workers comp

Private Pay Rates: 1st visit/Evaluation (including treatment): $130 follow-up Visits: $112/visit
**All Wellness services will be subject to a 6% sales tax starting Jan 1, 2023.
5 visits (includes eval) - 10% discount = $ 522.50+ tax = $553.85
10 visits (includes eval) - 15% discount = $ 990 + tax = $1049.40

A la carte services: subject to 6% sales tax
- Dry Needling: $50 for 30 min
- Manual Therapy/Medical Massage: $112 for 60 min
- Assisted Stretching: $60 for 30 min -

**All Physical Therapy visits being billed to ANY insurance must be considered medically necessary. It is the legal obligation by the PT to inform the patient when services are no longer considered Medically Necessary. At that time, the patient will be discharged. Services may continue as a Private Pay Wellness Program

Cancellation Policy
Please respect that when a last minute cancellation occurs or you are not home during the scheduled visit, that you are taking away a treatment from someone else that could have been scheduled. Optimal Life Therapy and Wellness will charge a **$30** fee for any missed appointments unless **24 hours notice is given.**

I acknowledge that I have received, read and agree to the Financial and Cancellation Policies.

X. _____

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Patient Responsibilities

Your Responsibilities Include:

- Provide Optimal Life Therapy and Wellness with a complete and accurate medical history
- Follow recommendations and advice prescribed by your Physical Therapist
- Participate in your care by performing exercises and asking questions
- Accept that the Physical Therapist always has the right to refuse treatment
- Inform the Therapist of any adverse reactions to treatment
- Treat the Therapist with respect and consideration
- Keep scheduled appointments and follow the Cancellation policy
- Inform the Therapist of any dissatisfaction or problems with care
- Provide payment for services within a reasonable timeframe

Patient Bill of Rights

- You have the right to know why we need to ask you questions.
- You have the right to have your personal Health care information kept confidential
- You have the right to refuse to answer questions.
- You have the right to ask for proper identification from providers
- You have the right to privacy during evaluations and treatments
- You have the right to be informed of any changes in staff
- You have the right to choose your health care provider
- You have the right to voice grievances without fear of retaliation
- You have the right to make decisions concerning your medical care including accepting or refusing medical treatment.

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Patient Medical History

- ❏ Cardiac Problems
- ❏ High Blood Pressure
- ❏ Pacemaker/defibrillator
- ❏ Stroke
- ❏ Neck or Back Problems
- ❏ Joint replacement
- ❏ Diabetes
- ❏ Cancer
- ❏ Neurological Problems
- ❏ Other:

Activities of Daily Living

How often do you do exercise?

❏ Daily ❏ 4-5x/wk ❏ 1-3x/wk ❏ never

Do you have any difficulty with any of the following exercises?

- ❏ Bed Mobility
- ❏ Sleeping
- ❏ Sitting
- ❏ Grocery Shopping
- ❏ Job activities
- ❏ Other:
- ❏ Stairs
- ❏ Walking
- ❏ Standing
- ❏ Meal Prep
- ❏ Household activities
- ❏ Dressing
- ❏ Toileting
- ❏ Lifting
- ❏ Driving the Car

Do you have pain? ❏ Yes ❏ No

If Yes, Where?

How Frequent is your pain:

❏ Constant ❏ Occasional

❏ Frequent ❏ Rare

Rate your pain on a scale 0-10 (0= no pain, 10= worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

What makes your pain better?

What makes your pain Worse?

I give permission for evaluation and treatment with Optimal Life Therapy and Wellness, LLC

X

Signature **Date**