WELCOME

The Opti-Health Group, Inc. (OHG) **welcomes** you as a patient to our rehabilitation therapy facility. It is our desire that your **experience** with us is a **positive** one. The information in this packet is extremely important for you to understand all that OHG is willing to do for you to allow you to accomplish your rehabilitative goals. Please ask a staff member to clarify any portion of this information packet that you do not fully understand. Names and phone numbers are listed below to assist you in contacting the person that can best assist you.

Facility phone number:.....419-422-5526

SCHEDULING

Scheduling your appointments is an important part of your care. We do our **best to accommodate** the personal needs of our patients. However, with a limited number of visits available in a day, it is best that you make your appointments as far in advance as possible. **Recovery is best accomplished by keeping your appointments**. If at any time you are unable to make your appointment, please call to cancel and reschedule. If you fail to show for an appointment, you will be called to reschedule within 24 hours. If you have 3 consecutive "no shows", you will be discharged and you will need to see your physician before returning to therapy.

PATIENT CARE

At OHG, you will be assigned to a team of licensed professionals. Your initial visit will include an evaluation of your injury. From this a comprehensive plan will be developed for you based upon the latest physical or occupational therapy advances. Your program will be monitored and progressed as you recover and your function improves. OHG's ultimate goal is for you to be independent in either a home exercise or aftercare program.

INSURANCE BENEFITS

It is essential that you understand your insurance benefits as they relate to physical therapy. Insurance companies can have several options for payment, which include visit limits, dollar amount caps, and pre-certification. Your insurance may combine therapy benefits along with other therapy types such as Chiropractic. This may reduce the number of visits you have available to you. You must also note that most DME (braces, splints, etc.) require pre-certification from your insurance **separate** from your physical therapy treatments. It is **your responsibility** to know your benefits and limitations and inform our office of any prior visits that may interfere with your coverage.

You may be responsible for charges that exceed these visits and/or your coverage benefits. Please call your insurance company to get your benefit information.

IN-NETWORK MATCHING

We are not contracted with all insurance companies, however OHG has an "in-network matching" policy. This means that we will accept out-of-network payments and adjust your account to match your in-network benefits for therapy services. This **does not** mean that your insurance payment is accepted as payment in full. You will still be responsible for any in-network deductibles and/or co-insurance as well as durable medical equipment (DME), per your insurance contract. For Medical Mutual and Anthem patients, any insurance payments that you may receive directly from your insurance company must be turned over to us along with the explanation of benefits. We cannot take contractual adjustments on your account without the explanation of benefits. This is in no way an enticement to you to use our facility; it is only our policy to decrease confusion brought about by the myriad of plans in the insurance market.

WORKER'S COMPENSATION PATIENTS

Every effort will be made to gain approval for your visits as to not allow for interrupted or delayed care. The BWC process can be long and tedious. We at OHG are willing to continue your care while you are in the process, however, if you exhaust all of your appeals and your claim is denied then we will bill your regular health insurance for the services. This could leave you with co-payments and deductibles obligations. If this burden becomes too great, then talk to one of our billing and collections representatives about a payment plan.

FINANCIAL POLICY

Proof of Insurance: Please bring your insurance cards(s) with you to every appointment. It is your responsibility to inform the front desk when the cause for treatment should be billed to a Med-pay (auto insurance), liability insurance company or worker's compensation instead of your regular primary insurance.

Payment is Due At Time of Service: All deductibles, co pays and non covered services are due at time of service unless payment arrangements have been made in advance. We accept cash, personal checks, and credit cards. If you have Medicare but Medicare deems the treatment as "medically unnecessary" according to HCFA payment guidelines, you will be required to sign a waiver (advanced beneficiary notice or ABN) prior to treatment.

Co-Pays: Pre-determined co pays are due when you check-in for your appointment. If your co pay is based on a percent (example 20% is patient responsibility) and you do not have a secondary policy, please be prepared to pay a minimum $20.00 on each date of service.

Our Responsibility to Report Non Compliance: It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay co pays and deductibles at time of service or who repeatedly "no show" for appointments. Please know that if you are reported, you could possibly lose your health care benefits. Contact human resources with your employer for further clarification of your benefits and obligations.

Financial Assistance: Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, or you are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with a billing and collections representative. You will need to provide a copy of last year's tax returns and current pay check stubs to be considered for assistance with our office.

Billing, Payments and Over Payments: If an overpayment is made by you on the account, a refund will only be issued if there are no other outstanding debts on other accounts containing the same guarantor or financial responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any change in address, phone, or employment. All balances are due in full within 14 days of the billing date. If you cannot pay the balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options. Canceled or returned checks will result in an additional $30 fee.

Past Due and Delinquent Account: Failure to meet your financial obligations may result in reporting you to the credit bureau, filing for a judgment in small claims court or other collection action against you. All attorney fees, court costs, interest charges, and other expense related to collecting your account will be added to your outstanding balance. If a collection agency is used to collect outstanding balances, Opti-Health will seek reimbursement for the agency's fee which is typically percentage based not to exceed 30%.

PATIENT ACKNOWLEDGEMENT

I have received and read the welcome packet of information provided to me on my first therapy visit. The information included policies and explanations about: Scheduling, Insurance Benefits, In-Network Matching, Co-pays, BWC, and Financial Policy. Phone numbers were included to answer any questions that I might have.

I agree to reimburse Opti-Health the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

_____	_____
Patient Signature	OHG Representative
_____	_____
Date	Date

The Opti-Health Group, Inc.
1725 Western Avenue, Suite B
Findlay, Ohio 45840
419-422-5526

PATIENT REGISTRATION

PATIENT INFORMATION				
Patient Name (First Middle Initial Last)	DOB:	SSN:		Sex: ☐ Male ☐ Female
Address:	City	State	Zip Code	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
Home Phone	Work Phone		Cell Phone	
May we leave messages? ☐Yes ☐No Patient Initials:	Would you like a text message appointment reminder ☐Yes ☐No		If yes, who is your cell phone carrier?	
Employer or School:	Address		Phone#	
Have you been a patient here before: ☐Yes ☐No If yes, when:				
Have you received therapy or chiropractic services elsewhere this year? ☐Yes ☐No If so, when:				
Was your injury work-related? ☐Yes ☐No Workers Comp Claim#	Was injury related to an auto accident? ☐Yes ☐No			
Are you currently receiving Home Health care? ☐Yes ☐No				
E-mail:				

SPOUSE INFORMATION		
Name:	DOB:	Home Phone: Cell Phone:
Employer:		

RESPONSIBLE PARTY INFORMATION		
Name:	DOB:	Home Phone: Cell Phone:
Address:	City, State, Zip	

EMERGENCY CONTACT INFORMATION	
Name:	Home Phone: Cell Phone:
Relationship:	City, State, Zip

REFERRING PHYSICIAN		
Name:	Office Phone:	Fax:

FAMILY PHYSICIAN		
Name:	Office Phone:	Fax:

INSURANCE INFORMATION	
Primary Carrier:	Insured Name: DOB
ID#	Insured SS#
Group Policy#	Employer:
Secondary Carrier:	Insured Name: DOB
ID#	Insured SS#
Group Policy#	Employer:

PLEASE READ & SIGN BELOW

It is **your responsibility** to understand your insurance benefits and limitations (i.e. visit limits, dollar amount caps, and pre-certification). Your insurance may combine therapy benefits with Chiropractic. If you have received therapy or chiropractic services, please inform your therapist. **Please call your insurance company to get your benefit information.**

I hereby authorize the release of any medical information necessary to process a claim for me and/or my dependent. I also authorize the payment of medical benefits directly to The Opti-Health Group, Inc. for services rendered in my care and/or the care of my dependent(s) realizing **I am personally responsible for the charges incurred, including items determined to be non-covered.** I agree to reimburse Opti-Health any collection agency fees, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts. I also authorize The Opti-Health Group, Inc. to render the care ordered by my physician and deemed necessary for this treatment. (If patient is a minor, a parent or guardian signature is required)

Patient Signature_____Date_____

Employee Witness_____Date_____

OptiHealth Therapy **Optimal Functional Ability**

PATIENT MEDICAL QUESTIONAIRE

Name:_____ Date:_____ DOB:_____ Age:___

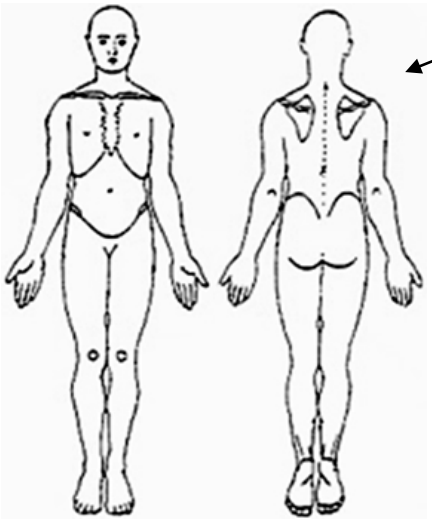
Occupation: _____ Employer: _____ Hrs/Wk: _____

What problem or diagnosis brings you here today? _____

Side of Injury/condition: ☐Right ☐Left Date of onset for injury/condition: _____

What are your main symptoms? _____

Describe how injury/condition occurred: _____



Shade your areas of pain or discomfort on the figures to the left:

Please rate your pain on the scales below from 0 to 10:
(0 = no pain; 10 = worst pain imaginable/emergency room pain)

Pain at rest: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Pain w/ activity: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What is the frequency of your pain? ☐Constant ☐Intermittent

Does your pain wake you at night? ☐Yes ☐No

How many times? _____

What eases your symptoms? _____

What aggravates your symptoms? _____

Are your symptoms getting ☐Better ☐Worse ☐Same Is your pain worse in the ☐AM ☐PM ☐Mid-Day?

Are you currently working? ☐Yes ☐No Job Status: ☐Full Duty ☐Light Duty ☐Off Work

Job Title:_____
Requires: ☐Heavy Activity ☐Moderate Activity ☐Light Activity

What activities at home, work, or recreational are you unable to perform? _____

Have you had a similar condition before? ☐Yes ☐No If yes, when _____

Have you had any diagnostic testing for your injury/condition? ☐Yes ☐No Results? _____

Check tests: ☐X-Rays ☐MRI ☐Bone Scan ☐CT Scan ☐Nerve Tests ☐Blood Tests
☐Other: _____

Have you had any other treatment for this condition? ☐Yes ☐No
If yes, what kind? ☐PT ☐OT ☐Chiropractic ☐Massage ☐Other: _____

Current Level of Physical Activity: ☐High ☐Medium ☐Low List:_____

What goals do you hope to accomplish with Physical Therapy?_____

_____

How did you decide to choose Opti-Health for your therapy?
☐My doctor ☐Family ☐Friend ☐Radio ad ☐Online ad ☐Newspaper ad ☐Billboard
☐Other (please disclose) _____

MEDICAL HISTORY:
Do you now or have you ever had any of the following? Check all that apply.

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Diabetes	☐	☐	Major Spinal Injury	☐	☐
Anxiety	☐	☐	Fainting Spells	☐	☐	MRSA	☐	☐
Arthritis	☐	☐	Fibromyalgia	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Fractures/recent or previous	☐	☐	Pacemaker/Nitroglycerin	☐	☐
Blackouts	☐	☐	Head Injury/Concussion	☐	☐	Polio	☐	☐
Blindness	☐	☐	Headaches	☐	☐	Recent Weight Loss or Gain	☐	☐
Blood Clot (DVT)	☐	☐	Hearing Problems	☐	☐	Seizures/Epilepsy	☐	☐
Bowel Problems	☐	☐	Heart Disease/Attack	☐	☐	Shortness of Breath	☐	☐
Cancer/Tumor	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Carpal Tunnel Syndrome	☐	☐	Hernia	☐	☐	Substance Abuse	☐	☐
Chest/Abdominal Surgery	☐	☐	High Blood Pressure	☐	☐	Swelling in Ankles	☐	☐
Chronic Cough	☐	☐	High Cholesterol	☐	☐	Thyroid Problems	☐	☐
COPD	☐	☐	Hypoglycemia	☐	☐	Tuberculosis	☐	☐
Current Infection(s)	☐	☐	Hypersensitive to Heat/Cold	☐	☐	Vascular Disease	☐	☐
Depression	☐	☐	Kidney/Bladder Problems	☐	☐			

☐Other conditions that may affect your response to therapy:

FALL HISTORY: (For individuals age 65 years & older)

Have you experienced any falls in the last 12 months?	☐Yes	☐No	How many?
Did you experience injury from a fall in the last 12 months?	☐Yes	☐No	
If yes what injuries?			

Medication Management: Please list current medications. This list must include all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements.			
Medication	**Dosage/Frequency**	**Route (oral/Injection, etc.)**	**Prescribed by**

List all allergies: _____

List all surgeries: _____

This information is correct to the best of my knowledge. Patient/Parent/Guardian Signature:	Date
Therapist Signature:	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Opti-Health Group, Inc.
PO Box 239 Findlay OH 45839-0239
Privacy Officer: Kevin Reiter, 419-422-5526

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

_____

_____

_____

I hereby acknowledge that I received or was provided the opportunity to receive a copy of **OHG's** Notice of Privacy Practices.

PATIENT INFORMATION

Print Name: _____

Signature: _____

Date: _____

Telephone: _____

PERSONAL REPRESENTATIVE INFORMATION (IF APPLICABLE)

Print Name: _____

Nature of Relationship: _____

(i.e. – Parent, Guardian, Beneficiary or Personal Representative of Deceased Patient, etc.)

Signature: _____

Date: _____

***For Office Use Only*:**

- □ Signed form received.
- □ Acknowledgment Not Obtained:
- □ Patient Refused.
- □ Emergency.
- □ Other - _____

Print Staff Member's Name: _____

Staff Member's Signature: _____

Date: _____