



**PLEASE PRINT CLEARLY**

DATE \_\_\_\_\_

PATIENT NAME (first) \_\_\_\_\_ (initial) \_\_\_\_\_ (last) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

PATIENT DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE (\_\_\_\_) \_\_\_\_\_ OCCUPATION \_\_\_\_\_

INSURED'S NAME (first) \_\_\_\_\_ (initial) \_\_\_\_\_ (last) \_\_\_\_\_

INSURED'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURED'S HOME PHONE (\_\_\_\_) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

INSURED'S DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

RELATION TO PATIENT \_\_\_\_\_ INSURED'S OCCUPATION \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

FULL NAME OF EMERGENCY CONTACT: \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

I, the undersigned, understand that an attempt will be made by this office to bill my insurance carrier for the physical therapy treatments rendered to me. However, should difficulties arise concerning reimbursement from my insurance carrier (example: partial payment, unreasonable time lapse, denial of payment for any reason, deductible, co-insurance, or any other balance not paid by my insurance) for whatever reason, I understand that I am financially responsible for all charges, including durable medical equipment (i.e. electrodes, etc.) whether or not paid by my insurance. It is the policy of Performance Physical Therapy, Inc. to submit claims for patients according to the information supplied by the patient. Without current, complete and accurate information, I understand that I am responsible for payment of any remaining balance. I understand that any co payment due by me is collected by this office at the time services are rendered. I understand that this office *does not* bill secondary insurance and it is my responsibility to collect any amount due to me by secondary insurance. I agree to pay a late charge of \$20.00 on any unpaid balance for which I have been billed that is not paid in a timely manner. I hereby authorize Performance Physical Therapy, Inc. to release any and all information necessary to secure payment.

PATIENT SIGNATURE (Parent if Minor) \_\_\_\_\_ Date \_\_\_\_\_

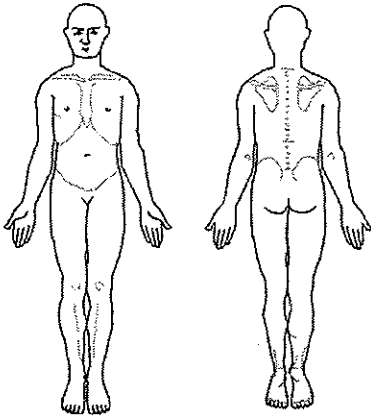


**Hockessin**  
 Stone Mill Plaza  
 720 Yorklyn Road  
 Suite 150  
 Hockessin, DE 19707  
 302-234-2288 Tel  
 302-234-2869 Fax

**North Wilmington**  
 Lombardy Center  
 410 Foulk Road  
 Suite 106  
 Wilmington, DE 19803  
 302- 764-2288 Tel  
 302-234-2869 Fax

**Mill Creek**  
 Mill Creek Medical Center  
 4512 Kirkwood Highway  
 Suite 101  
 Wilmington, DE 19808  
 302-254-2288 Tel  
 302-234-2869 Fax

Please shade in areas where pain or abnormal sensations are present.



**History of Present Condition**

1. What are your symptoms?

---



---



---

2. When did your symptoms begin?  
 (Please indicate a specific date if possible)

---

3. Have you had any previous treatment for this condition? (Check all that apply)

- None
- Physical therapy
- Joint manipulation
- Exercise
- Massage therapy
- Traction
- Bracing/taping
- Injection into the spine
- Casting
- Injection into the skin/muscles
- Other \_\_\_\_\_
- Medication (oral)
- Hypnosis
- Biofeedback
- TENS unit
- Acupuncture
- Bed Rest
- Overnight hospitalization

4. Have you had any of the following tests?

- X-Rays
- CT Scan
- MRI
- Arthrogram
- Stress X-Ray Test (Telos)
- Other \_\_\_\_\_
- Bone Scan
- NCS
- Fluoroscope
- Vestibular

Test Results: \_\_\_\_\_

**Medication**

Please list any **prescription** medications you are currently taking (pain pills, injections and/or skin patches ect):

---



---



---

Prescribing MD: \_\_\_\_\_

Are you currently taking any of the following over the counter medications?

- Aspirin
- Tylenol
- Antihistamines
- corticosteroids
- other \_\_\_\_\_
- Vitamins/mineral supplements
- Advil/Motrin/Ibuprofen

**Past Medical History**

Have you ever had/ been diagnosed with any of the following conditions?

- Cancer (type) \_\_\_\_\_
- High blood pressure
- Stroke
- Kidney problems
- Thyroid problems
- Diabetes
- Arthritis
- Stomach problems
- Circulation/vascular problems
- Parkinson's Disease
- Infectious Diseases (i.e. hepatitis, tuberculosis)
- Rheumatoid Arthritis
- Multiple Sclerosis
- Other \_\_\_\_\_
- Heart problems
- Lung problems
- Blood disorders
- Epilepsy/Seizures
- Allergies
- Osteoporosis
- Head Injury
- Broken bone

Please list any recent/relevant past surgeries related to your current problem:

Surgery	Date

**Family History**

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

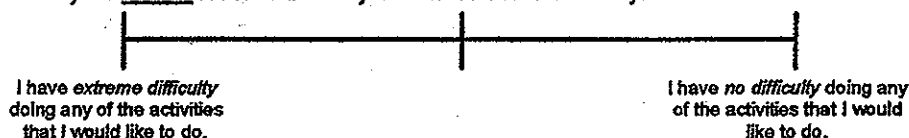
- Osteoporosis
- Heart disease
- Stroke
- Psychological conditions
- Cancer
- Arthritis
- High Blood Pressure
- Other \_\_\_\_\_

## OPTIMAL INSTRUMENT

### Difficulty-Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking-short distance	1	2	3	4	5	9
10. Walking-long distance	1	2	3	4	5	9
11. Walking-outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an "X" at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1.      2.      3.     

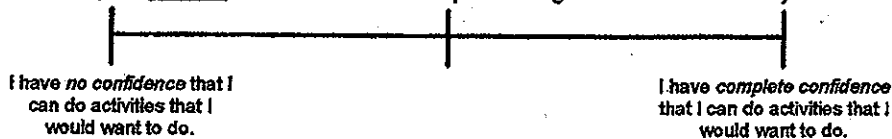
© 2005, 2006 American Physical Therapy Association. All rights reserved. No part of this instrument may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise without prior permission of the American Physical Therapy Association. Contact [permissions@apta.org](mailto:permissions@apta.org) or visit [www.apta.org/publications](http://www.apta.org/publications).

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515-530.

### Confidence-Baseline

Instructions: Please circle the level of confidence you have for doing each activity today.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking-short distance	1	2	3	4	5	9
10. Walking-long distance	1	2	3	4	5	9
11. Walking-outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all the activities you like to do, please mark an "X" at the point on the line that best describes your overall level of confidence in performing these activities today:



© 2005, 2006 American Physical Therapy Association. All rights reserved. No part of this instrument may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise without prior permission of the American Physical Therapy Association. Contact [permissions@apta.org](mailto:permissions@apta.org) or visit [www.apta.org/publications](http://www.apta.org/publications).

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515-530.



American Physical Therapy Association

OPTIMAL INSTRUMENT
Demographic Information

- 1. Date of Birth
2. Sex
3. Race
4. Ethnicity
5. Insurance
6. Education
7. Please check the combined annual income of everyone in your house:
8. Employment/Work
9. Do you use a:
10. With whom do you live?
11. Where do you live?

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). Phys Ther. 2005;85:515-530.



North Wilmington  
(302)764-2288

Hockessin  
(302)234-2288

**YOUR BENEFITS**  
**\*\*\*\*\*IMPORTANT\*\*\*\*\***

We **CANNOT** guarantee that the insurance benefit information we obtain from your insurance carrier is correct. For this reason, we require **you** to contact your insurance carrier to **confirm** your specific benefits. We make every attempt to accurately confirm your financial responsibility for your rehabilitation.

Co-pay charges are based on the information your insurance company provides when we call for your benefits; however, the amounts are estimates. The final co-pay amounts due are determined by your insurance company at the time the claims are received, and sometimes this amount differs from what we collect at the time of service.

Performance Physical Therapy and Fitness, Inc., does not bill secondary insurance companies. Please contact your **PRIMARY** insurance company and request them to crossover your co-pay responsibility to your **SECONDARY** insurance co.

I fully understand that the **FINAL DETERMINATION OF CO-PAY** is taken from the Explanation of Benefits received from my insurance company. I understand that I may owe more co-pay as a result of the above procedure.

I further fully understand that I will be billed and financially responsible for any and all charges not paid by my insurance company and a late charge of \$20.00 will be assessed to any unpaid balance for which I have been billed that is not paid in a timely manner.

**ATTENDANCE POLICY**

It is important that you keep your scheduled appointments. You are more likely to see steady progress and maximize your insurance coverage by attending consistently. Your regular attendance also allows us to meet the needs of all our patients effectively.

If you have a scheduled appointment that must be cancelled, please provide at least 4 hours advance notice to avoid a \$25.00 cancellation fee. Payment of the cancellation fee is expected at your next scheduled appointment.

Thank you for your cooperation in helping us to treat you and others as effectively as possible. Please sign below to indicate that you understand our attendance policy.

**PRIVACY POLICY**

I have read and been offered a copy of this facility's privacy policy. (Effective April 14, 2003)

**I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.**

Signature (parent or guardian if under 18) \_\_\_\_\_

Date \_\_\_\_\_

# Notice of Privacy Practices

Effective Date April 14, 2003

We know that your medical and health information is private. We do our best to protect that information. The purpose of this notice is to explain how we protect that information and what rights you have regarding the information. You have the right to receive a Notice of Privacy Practices that details how everyone at Performance Physical Therapy protects your rights. By everyone, we mean therapists, assistants, students, volunteers, support staff, and anyone who might see your information or put information in your record.

We at Performance Physical Therapy can use and give out your information to anyone who has a role in taking care of you. This includes doctors, therapists, trainers, aides and assistants. We can also give out your information to Medicare or any other insurance company or individual who may be responsible for paying for your care and services you receive.

We may use your information to find ways to improve your care, to see how our employees are performing their jobs, and to see how we compare to other facilities. Some state or federal laws require us to report certain diseases, abuse and crimes and certain other things. We may share information to find programs or services that might help you get better or stay better.

You have the right to:

1. To considerate, respectful service with identification of your needs including safety and comfort.
2. To have your pain assessed and managed properly.
3. To be free from physical and mental abuse and/or neglect.
4. To have access to treatment or accommodations that are available and indicated regardless of race, creed, sex, national origin, age, disability, veteran status, source of payment, sexual orientation or any other factor that may form the basis for discrimination.
5. To be told of your rights as a patient at the earliest possible time in your service.
6. To confidentiality, regarding your medical care and all information related to that care, as supported by the following rights:
  - a. To refuse to talk with or see anyone not directly involved in your care.
  - b. To be interviewed and examined in surroundings designed to provide reasonable visual and auditory privacy. This includes the right to have a person of one's own sex present during certain parts of physical examination, treatment or procedure performed by a health professional of the opposite sex.
7. To know the names of your treating therapists and the names and duties of other staff having direct contact with you.



8. To have information necessary for you to understand your condition and to be a part of planning your treatment.
9. To obtain information in your medical record, upon request, unless such information is specifically restricted by your physician.
10. To open disclosure should an unanticipated outcome occur including those potentially associated with an error in care.
11. To obtain an interpreter or other aides, where possible, if you do not understand the predominant language of the community or have a communication deficit.
12. To be told what the healthcare provider proposes to engage in or perform medical research/educational projects affecting your care or treatment. You have the right to refuse to be a part of such activity.
13. To refuse treatments or services. A healthcare provider shall tell you of the possible outcomes of your refusal.
14. To expect, upon discharge of service, information about your continuing health care needs and the means for taking care of them.
15. To receive and review an explanation of charges related to your care.
16. To share concerns about policies and services with a representative of the facility without restraint, interference or reprisal.

**You are responsible:**

1. For being considerate of other patients and Performance Physical Therapy staff by:
  - a. Treating staff with respect.
  - b. Respecting the property of others.
  - c. Treating health care and rehabilitation equipment with care and safety.
  - d. Assuring privacy of other patients when in the facility.
  - e. Reminding family/companions to maintain a quiet atmosphere, and follow all facility policies.
2. For providing accurate and complete demographic information as well as present and past illnesses, hospitalizations, medications, allergies and other matters related to your health.
3. For telling your health care provider about changes in your health, medications, insurance, financial status of service provider.
4. For following the treatment plan given by your health care provider. Let your health care provider know immediately if you do not understand or cannot follow the plan.
5. For your actions if you refuse treatment or do not follow the plan of the health care provider.

**6. For seeing that your health care costs are paid as soon as possible.**

**7. For your valuables and personal belongings.**

**If you have any concerns or questions regarding this policy, please feel free to contact the facility management at 302-234-2288.**

**4/2003  
update 11/2004  
Privacy Practices**