

## Jefferson Location

102 E. Commerce Ct  
Jefferson City, TN 37760  
(P) 865-475-3101  
(F) 865-475-9213  
Hours: 8A-5P~Mon-Fri  
Optimus@optimustherapy.com



## Dandridge Location

118 E. Meeting St, Suite A  
Dandridge, TN 37725  
(P) 865-895-4080  
(F) 865-329-7933  
Hours: 8A-5P~Mon-Fri  
Dandridge@optimustherapy.com

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Sex: M/F/Other \_\_\_\_\_ Height: \_\_\_\_ ft \_\_\_\_ in Weight: \_\_\_\_ lbs. Marital Status: S / M / D / W

Home #: \_\_\_\_\_ - \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Can we send you text reminders? Y / N Can we leave messages on your home phone VM? Y / N

Emergency Contact: \_\_\_\_\_ #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Have you received Physical Therapy in the past 12 months? Y / N If yes, Where: \_\_\_\_\_

If you received Home Health/ PT when was the last time you were seen? \_\_\_\_\_

Occupation: \_\_\_\_\_ Duty Level: Full Time / Part Time / Light Duty / Not Working

Employer: \_\_\_\_\_ Employer's #: \_\_\_\_\_

Is this a Work-Related Injury? Y / N Is this injury from an Auto Accident? Y / N

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Adjuster: \_\_\_\_\_ Adjuster's #: \_\_\_\_\_

Other than yourself, is there anyone you allow us to discuss your therapy with? \_\_\_\_\_

Referring Physician: \_\_\_\_\_ How did you hear about Optimus? \_\_\_\_\_

### Medical History

Reason for coming to therapy: \_\_\_\_\_

When did your pain/injury start? \_\_\_\_\_ Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this episode of care related to a fall? Y / N Number of fall in the past 12 months: \_\_\_\_\_

Are you pregnant? Y / N Are you a smoker? Y / N Are you on blood thinner? Y / N

Do you have any allergies: \_\_\_\_\_

Do you have any implants: (Circle all that apply) Defibrillator / Deep Brain Stimulator / Pacemaker

What activities are you limited from due to pain: \_\_\_\_\_

Have you had any kind of testing for this injury: MRI / Xray / Ct scan / Other \_\_\_\_\_

**Past Medical History:** Please check all that apply

<input type="checkbox"/> Angina	<input type="checkbox"/> Anxiety/Panic Attacks	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Back Injury	<input type="checkbox"/> Bladder Problem
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Breathing Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Cellulitis
<input type="checkbox"/> Circulation Issues	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> COPD	<input type="checkbox"/> Covid-19
<input type="checkbox"/> Current Infection	<input type="checkbox"/> Current Pregnancy	<input type="checkbox"/> Degenerative Disk Disease
<input type="checkbox"/> Diabetes Type I	<input type="checkbox"/> Diabetes Type II	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Ehlers Danlos Syndrome	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteopenia	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Issues	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Upper GI Disease	<input type="checkbox"/> Urinary Incontinence	<input type="checkbox"/> Vertigo

Do you have pain? Y / N Location of Pain: \_\_\_\_\_

Describe your pain: (Circle all that apply) Dull / Nagging / Throbbing / Stabbing / Aching / Burning

Radiation: Y / N Where: \_\_\_\_\_

What makes your pain better? \_\_\_\_\_ Worse? \_\_\_\_\_

Are you better when: Moving / Still Since onset is it: Better / Worse Is it worse: AM / PM

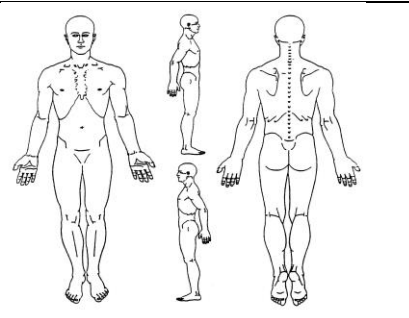
How did your symptoms start: Sudden / Gradual Does medication relieve any pain Y / N / Other \_\_\_\_\_

How often are you in pain: Intermittently / Occasionally / Frequently / Constantly

Please rate your pain on a scale of 1 to 10 (1 being the least and 10 being the worst): \_\_\_\_\_

What hobbies / sports are you involved in: \_\_\_\_\_ If sports, what position: \_\_\_\_\_

Please mark specifically where and what type of pain you are experiencing:

<p><b>Key:</b> ///// Stabbing</p> <p>Xxxx Burning</p> <p>oooo Pins and Needles</p> <p>_____ Numbness</p>	
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What is your specific goal for therapy: \_\_\_\_\_

When is your next doctor's appointment: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient / Guardian Signature if Patient is below 18: \_\_\_\_\_

## **AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS, AND PAYMENT POLICY**

I, \_\_\_\_\_ (Print Name) hereby authorize to submit claims and payments be made directly to Optimus Health Center, for healthcare services provided to me by Optimus Health Center INC. I hereby certify that the insurance information that I have provided Optimus Health Center Inc. Is true and accurate as of the date of service and that I am responsible for keeping it updated for any changes.

I also understand that my insurance may not pay 100%, and that I am responsible for any health insurance deductibles and co-pays. I understand that **all bills are due and payable upon receipt**, and that the patient responsibility portion of my bill such as co-pay is due and payable at the time of service. I understand that should my account with Optimus Health Center become delinquent it will be turned over to a collection agency, and that I will be responsible for paying all collection agency fees, court cost, or any other fees associated with resolving my account. And in any event that I have an outstanding balance, I understand that Optimus Health Center reserves the right to refuse service until the balance is paid in full or some payment arrangement has been made.

We are happy to accept personal check, however, if your check is returned for any reason, you will receive a new bill for the amount of the check plus any applicable fees associated with the returned check.

I consent and allow Optimus Health Center Inc. to use and disclose my protected health information (PHI), to obtain payment for health care operations, including coordination with other health care providers and to carry out treatments. My PHI may be disclosed to my insurance or their agents in order to verify benefits, authorize services and to process medical claims. (Please refer to the Notice of Privacy Practices for more details on PHY disclosure).

I understand that in the event that I choose to pay in private that I fully accept full financial responsibility, including charges incurred through health plans that do not cover services.

**As a courtesy to our patients, Optimus Health Center will do our best and make every effort to verify your eligibility and benefits from your insurance after the initial evaluation. The benefit information obtained from your insurance company cannot be considered as a guarantee of benefits. We suggest that you contact your insurance as well to verify your benefits.**

**I hereby allow Optimus Health Center Inc. As its staff to provide treatment procedures that are reasonable and medically necessary according to their professional judgement in coordination with my physician if needed.**

I hereby acquit, discharge Optimus Health Center Inc. including its staff and any of its employees of any wrongdoing against any kind of liability or claims of any kind resulting from my refusal to allow any emergency care or any medical care when deemed necessary. If I signed up for E-Statements, I will not hold Optimus Health Center liable for any unintentional misdirected emails.

**I acknowledge that I was offered a copy of the Notice of Privacy Practices** and that it is also posted in the clinic for my review.

If you have any concerns regarding your PHI, you can contact the Privacy Officer – Mila Pacia 865.475.3101

**I, the undersigned, have read and understand the statements as outlined above.**

Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

## **IMPORTANT CLINIC POLICIES**

### **Welcome to Optimus Health Center. We care about you!**

We try to give all our patient get the best care possible, and to help us achieve this we have a few house rules that we adhere to in order for us to give you as well as our other patients the time necessary to obtain the maximum benefit and outcome from each of your therapy session.

**Late Policy: Please arrive on time for your appointment,** if you cannot make it on time please call us, if you are running **15 or more minutes late**, we will try our best to accommodate you. Your treatment may need to be modified or rescheduled in consideration of our other scheduled patients.

**Frequent Cancellation or No Shows:** After 3 times that you miss your appointments without any calls to cancel or reschedule, we may ask you that you return to your physician prior to scheduling more appointments.

**24 Hour Notice on Cancelling Appointments:** We require at least 24 hours' notice to allow us to schedule another patient that may be in need of an appointment for that day.

**Children and family Members in the therapy gym:** Children requiring supervision other than a patient is not allowed in the treatment area. If your child does not require supervision and is capable of waiting quietly for you then you may bring them, we reserve the right to reschedule or cut your treatment session short if your child causes any disturbance. Any family member of patients over 18 years of age is not allowed in the treatment area as this violates the privacy of our other patients.

**Attire:** Please wear comfortable loose clothing to make it easy for us to treat the area that we need to work on. For our Aquatic Therapy patients, we recommend that you wear a polyester blend type of clothing if wearing something our Aquatic Therapy patients we recommend that you wear a polyester blend type of clothing if wearing something other than normal swim wear.

**Cell Phones:** Must be tuned off at all times, taking pictures inside the therapy gym is not allowed as this violates the privacy of our other patients.

**Medical Photography:** As part of your medical records your therapist may take a picture of the area being treated, to be used to monitor your progress or share with other healthcare providers involved in your care. Please indicate below as to what you agree on how we can use those images.

Medical Records \_\_\_\_ Monitor progress \_\_\_\_ Teaching purposes \_\_\_\_ Publication \_\_\_\_

Or I do not provide consent to allow or saving of any medical photograph in my medical records \_\_\_\_

You are guaranteed that refusal to consent for medical photography will not affect your medical care.

**We look forward to building a lasting relationship with you that will last a lifetime. If you have any concerns or questions about your care, please do not hesitate to talk to us.**

**Signing below indicates that you agree with the statements mentioned above.**

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**Patient Signature / Or Guardian if patient is below 18 y.o**

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**Date**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

[illegible]

Patient Signature and Date: \_\_\_\_\_