



OPTCI

**OSTEOPRACTIC PHYSICAL THERAPY
OF CENTRAL INDIANA**
ORTHOPEDIC AND PELVIC HEALTH SPECIALIST

Patient Information

Patient Name: _____
(First) (M.I.) (Last) (Nickname)

Address: _____

City: _____ State: _____ Zip Code: _____

Home or Cell Phone: _____ Age _____

Date of Birth: _____ Occupation: _____

Physician: _____ Insurance Co. _____

Yearly Deductible: _____ Do you have an HSA/FSA? Yes No

Patient Health Questionnaire

Do you have any pain? Yes No

Location: _____ Pattern: _____

Have you been seen by a medical professional already for your pain? Yes No

If yes, please mark all that apply:

- Primary Doctor
- Chiropractor
- Ortho Surgeon
- Dentist
- Physical Therapy



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- ER
- Acupuncture
- Nurse Practitioner
- Other

When did your current pain begin/start? _____

What started or initially caused your pain? _____

Are your symptoms getting: Better Worse

What activities/movements/positions increase your pain? _____

What activities/movements/positions decrease your pain? _____

Are you taking medications for your pain? (If yes, please list all medications)

- Yes No

On a **zero to ten** Scale (0 = no commitment/10 = fully committed), how committed are you to resolve your pain?

- | | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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Are you currently experiencing or do you have any history of the following?

Conditions	<i>I have none of these conditions:</i> <input type="checkbox"/>		Symptoms	<i>I have none of these symptoms:</i> <input type="checkbox"/>	
High blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent fever, chills, sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Peripheral vascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Visual Disturbances	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spinal Cord Stimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ringing in ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke/TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung Disease/COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unexplained weight changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood thinners	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoarthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autoimmune disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bowel & bladder difficulty	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary tract infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Upper respiratory infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Social History		
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you sleep well?	Yes	No
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you drink alcohol?	Yes	No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you use tobacco?	Yes	No
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you exercise regularly?	Yes	No

If **yes** to any condition above, please explain:

List any known allergies: _____

List any previous surgeries: _____

I authorize that the information this Patient Health Questionnaire form is true to my knowledge.

Patient/Guardian Signature:



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Payment for Services Rendered

Osteopractic Physical Therapy of Central Indiana LLC does not have a relationship with any health insurance and is a private-pay clinic. There are no insurance limitations, co-pays, deductibles, or surprise bills with this service. It is **the patient's responsibility** to pay for the services provided with cash, check, credit card, debit card, flexible spending accounts, health savings accounts, or financing through Care Credit.

You will receive a "good faith estimate" and know the exact cost of your treatment plan once the evaluation is completed. There is no hidden fees or miscellaneous bills with our services.

You may, depending on your health insurance, submit a claim to your health insurance company for reimbursement after services are completed. Osteopractic Physical Therapy of Indiana, LLC will provide a reimbursement form for you after your treatment plan is completed, which is necessary for you to submit a claim to your insurance company.

If you purchase a treatment package, you have a money-back guarantee that can be accepted within the first four treatment sessions and the amount paid will be refunded to you.

I agree and understand the above statements:

Patient/Guardian Signature:
Date

Emergency Contact

In case of an emergency, we should contact:

Name:

Relationship:

Phone Number:

317-922-3316 : Tel.#
info@optci.com : E-Mail
www.optci.com : Web



Testimonial Approval

After we accomplish all of your goals and the results we initially promised at the evaluation, we like to share our patient success stories as a testimonial. Of course, with your permission first!

"I hereby authorize Osteopractic Physical Therapy of Central Indiana LLC to use and publish my testimonial that may contain my image, my content, and likeness. I agree and understand I shall neither be compensated for the content nor receive attribution for the content. I also attest that I am authorized to grant the right to use this content. I understand that this content may be used in publications, press releases, marketing materials, advertisements (both digital and print), websites (including social media sites), or other uses. This authorization is continuous, and only I may withdraw this authorization through specific, written rescission."

I agree with and understand the above statement: Yes No

Cancellation and Late Policy

24 HOUR CANCELATIONS – Every patient will receive a text confirmation the day prior to their appointment. If you need to cancel, you can cancel at this time without any penalty.

SAME DAY CANCELATIONS – If you happen to no show or cancel on the same day of a treatment then a penalty of one treatment visit charge is enforced.

LATE EVALUATIONS: If you are late to an evaluation, you can contact Osteopractic Physical Therapy of Central Indiana directly at 317-922-3316 and decide whether you would like to continue with the evaluation or reschedule. If you are < 15 min late, the duration of the evaluation will still end on the scheduled time and cost will still be the same to complete the evaluation. If you are > 15 min late, it is left up to the discretion of the therapist regarding rescheduling versus completing a shorter evaluation with less or no treatment. The eval will still end at the scheduled time and the cost is the same.

LATE TREATMENT APPOINTMENTS: If you are going to be late to a treatment appointment, you can contact Osteopractic Physical Therapy of Central Indiana directly at 317-922-3316 and decide whether you wish to continue with your appointment or reschedule. If greater than 15 minutes, you can reschedule or choose to pursue a shorter treatment, but the session will still end at the same scheduled time.

I agree and understand the above statements Yes No



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Informed Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and/or treatment of my condition by a licensed physical therapist employed by Osteopracitic Physical Therapy of Central Indiana LLC.

The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation, and course of treatment.

The physical therapist has informed me of the expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition.

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning treatment and options available for my condition.

I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. In the event of a change in medical status, I understand that my treatment may be modified, stopped or referred out to the proper practitioner. I reserve the right to withdraw at any time.

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Printed Name:

Patient/Guardian Signature:

Date:

Relation of signer to Patient, if signed by person other than Patient:

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge that Osteopractic Physical Therapy of Central Indiana has provided me with a copy of its Notice of Privacy Practices, which explains how my protected health information will be handled in various situations as permitted by law.

I understand that I may discuss my concerns and/or any questions I have concerning this Notice of Privacy Practices with the Osteopractic Physical Therapy of Central Indiana, LLC representatives.

Patient/Guardian Signature:

Date:

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