



NEW PATIENT INFORMATION

Patient's Name _____ MI _____ DOB _____ SS# _____ - _____ - _____

Street Address _____

City _____ State _____ Zip _____ Home Phone# _____ Cell# _____ Wk# _____

check if okay to leave message: cell _____ hm _____ Work _____ Referring Doctor _____

Email Address: _____

FINANCIALLY RESPONSIBLE PARTY

Name _____ MI _____ DOB _____ SS# _____ - _____ - _____

Employer _____ Occupation _____

Marital Status S M D W Spouse's Name _____ Spouse's Date of Birth _____

Spouse's SS# _____ Spouse's Employer _____ Spouse's Work# _____

Emergency contact not living with you _____

Address _____ Phone # _____

INSURANCE

Primary _____ Secondary _____

Worker's Compensation/Auto Accident Co. Name _____ Claim # _____

Adjuster Name _____ Adjuster Address _____ Date of Injury _____

Adjuster Phone Number _____ Adjuster Fax Number _____

Attorney Handling Your Case _____ Phone # _____ Fax # _____

Address _____

I authorize Integrative Physical Therapy and Spine Treatment Center, inc (IPT), to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly (IPT). I agree that a reproduced copy of this authorization will be valid as the original. Per your insurance, this is not a guarantee of payment; all claims are subject to review according to your plans provisions. As a courtesy we will bill and verify your medical benefits, at no time is it our responsibility to monitor your plans dollar or visit maximums, as this is the patients' responsibility. I understand that I am responsible for any amount not covered and that the balance is due upon receipt. All accounts that have not been paid in full within 120 days from the original date of service will be turned over to our Cornerstone Credit Services, LLC. Each account will be subject to a 1.5% finance charge per month. We have a \$25.00 Returned Check fee for all returned checks. This information may be released to a collection agency and/or credit bureau in the event my bill is not paid in a timely manner to be determined by the creditor. A full disclosure of insurance coverage is mandatory due to the nature of the treatment you are receiving at (IPT). Once the initial verification is completed any further disclosures will result in the patient being held responsible for billing a secondary insurance. (IPT) will not be held responsible for any non-covered or over the usual and customary expenses that is determined by the insurance company. Any balance remaining is ultimately the patients' responsibility.

Signature of Responsible Party _____ Date _____



Consent for Treatment

As a patient of Integrative Physical Therapy and Spine Treatment Center, Inc (hereafter referred to as Integrative PT), I, _____ understand that treatments administered to me by the staff of Integrative PT, while having the purposes of decreasing pain and improving function, may cause side effects including, but not limited to: soreness, stiffness, and fatigue. I further understand that failure to comply with treatment recommendations or instructions given to me by Integrative PT staff, and relating to my treatment or follow-up care, will affect my treatment outcome and may negate any progress made during treatment.

Although every effort will be made to maximize my progress while a patient of Integrative PT, I do understand that it is impossible to predict or control the outcome in every treatment situation.

I understand that if I no show without calling for 2 appointments, cancel more than 3 appointments in a row or I am 10 minutes late for 4 appointments, I will be discharged from Integrative PT due to non-compliance with the treatment plan.

I understand the above information and hereby consent to allow the staff of Integrative PT to direct and provide my therapy and/or rehabilitation services as deemed appropriate by my physician or treating therapist.

Patient's Signature

Date

Integrative Physical Therapy and
Spine Treatment Center, Inc.
Physical Therapist

Date

Notice of Privacy Practices for Patients (HIPAA)

This notice explains how medical information about you may be used and disclosed. It also details how you can get access to this information. Please review it carefully and then sign at the bottom as acknowledgement of receipt of this notice. You may be provided with a copy of this notice if requested.

- In a constantly changing healthcare environment, our practice is committed to educating our patients about healthcare issues that affect them. As a result, we have provided below general information about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for your review. Our practice is complying with HIPAA's regulations and would be happy to answer any additional questions you might have.
- The Privacy Rule is part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The Privacy Rule establishes a federal requirement that doctors, hospitals or other healthcare providers and health plans provide a copy of their Notice of Privacy Information Practices to each of their patients. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
- Integrative Physical Therapy and Spine Treatment Center, Inc is required by law to be compliant with the Privacy Rule by April 14, 2003.
- Protected health information (PHI) means any personal health information as defined by law, including demographic information that is collected from a patient by a healthcare provider or other entity that could potentially identify the individual. PHI includes all medical records and other individually identifiable health information held or disclosed regardless of how it is communicated (e.g. electronically, written, or verbally).
- TPO refers to the treatment, payment or healthcare operations of Integrative Physical Therapy and Spine Treatment Center, Inc
- In other words, our practices can use or disclose PHI for performing any activity that it deems necessary for: 1) providing quality patient care, 2) ensuring that our practice gets paid for services, and 3) operating our practice. Some examples of these activities are use of PHI by the physical therapist and clinical staff to treat a patient, use of PHI by the business office staff to verify insurance information for billing purpose, use of PHI to obtain a referral, and use of PHI for our practice's business planning and internal management activities.

I understand that Integrative Physical Therapy and Spine Treatment Center, Inc may share my health information for treatment, billing, and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand the organized healthcare arrangement has the right to change this notice at any time. I may obtain a current copy by contact Integrative Physical Therapy and Spine Treatment Center, Inc.

My signature below constitutes my acknowledgement that I have been provided with the information above, and that a copy of the notice of privacy practices is available to me upon my request.

Signature of Patient or Legal Representative

Date



Office Policy Regarding Your Appointments

Please be aware that we will accommodate your schedule to the best of our ability; however, appointments are scheduled on a “first come – first served” basis. We do ask that patients not currently working be flexible in scheduling their appointments during the mid-morning and mid-afternoon. This allows working patient’s access to morning, lunch hours and late afternoon appointments and minimizes their loss of work time.

We understand that at times an illness or emergency may cause you to miss or cancel an appointment. However, because there are a large number of patients waiting to utilize our therapy services, missed appointments are unfair to these patients and are detrimental to your care. Repeated cancellations and/or failure to comply with treatment will result in discontinuation of care.

VAX-D patients should be aware that the effect of the treatment is cumulative and therefore, we strongly discourage any missed appointments because it is so critical to your care.

If you are late for an appointment, we will make every attempt to complete your entire treatment; however, this may not be possible if there is a patient scheduled immediately after you. If you are more that 10 minutes late, we may need to re-schedule your appointment. If you’re here as scheduled and we do not initiate your treatment on time, you will receive full treatment.

Office Policy Regarding Your Insurance

As a courtesy we verify and bill your insurance company for out patient physical therapy benefits. Per your insurance, this is not a guarantee of benefits or payment for services rendered. All claims are subject to review in accordance to the terms of your contract.

If at any time, you have questions or concerns with the quality of care you are receiving, please feel free to discuss your concerns with our administrator. We continually strive to provide you with individualized attention as provided by experienced specialists. We will attempt to satisfy your expectations and maximize your progress.

Patient’s Signature _____ Date _____



Name: _____ Date: ___/___/___

Referring Physician: _____ Phone Number _____

Date of Birth: ___/___/___ Last MD Appointment: ___/___/___ Next MD Appointment: ___/___/___

The following is very important in our evaluation process. Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

2. Do you have any history of the following: Yes No

Circulatory problems ___ ___

High blood pressure ___ ___

Heart trouble ___ ___

Pacemaker ___ ___

Epilepsy ___ ___

Diabetes ___ ___

Pregnancy ___ ___

Blackouts ___ ___

Visual disturbances ___ ___

Weight change (more than 15 lbs.) ___ ___

Headaches ___ ___

Ringing in ears ___ ___

Bowel or bladder problems ___ ___

Malignancy ___ ___

Stroke ___ ___

Aneurysm ___ ___

Pelvic Pain..... ___ ___

Tail bone injuries ___ ___

Respiratory ailments? (please specify) _____

If you checked yes to any of the above, is your Dr. aware of these issues. Yes _____ No _____

2. List any other past medical history not addressed above. (Include surgeries, childbirth, traumas, or other medical issues).

3. Do you have and known allergies?

4. In the space below, describe your symptom(s) specifically:

a. What is your primary complaint that brings you to therapy?

b. Secondary complaint?

5. What date did your symptoms begin (specific, but if unknown then approximate)? _____

6. How did your symptom(s) begin?

7. Have you ever received treatment for this condition? Yes or No
If yes, for how long?

8. PATIENT GOALS: List what you would like to be able to do as a result of therapy.
The activity, how often, for how long, by when?

1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____

