



It is our policy to consider all patients without regard to race, color, religion, gender, national origin, age, or mental/physical disability. Information obtained regarding any of these characteristics will be recorded solely for informational purposes and will be considered only as required to determine the type and level of care to be provided.

NAME: _____ **BIRTHDATE:** _____ **SS #:** _____

ADDRESS: _____ **PHONE #:** _____ **CELL #:** _____

CITY, STATE, ZIP: _____

MARITAL STATUS: M S W D **SEX:** F M **AGE:** _____

EMERGENCY CONTACT PERSON: _____ **RELATIONSHIP:** _____

ADDRESS: _____ **PHONE #:** _____ **CELL #:** _____

CITY, STATE, ZIP: _____

FAMILY PHYSICIAN: _____ **PHONE #:** _____ **FAX #:** _____

PATIENT EMPLOYER: _____ **PHONE #:** _____

ADDRESS: _____

CITY, STATE, ZIP: _____

RESPONSIBLE PARTY/GUARDIAN (IF OTHER THAN PATIENT): _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

RESPONSIBLE PARTY EMPLOYER: _____ **PHONE #:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

INJURY INFORMATION: Is your condition a result of (**please check one**):

Work Related Injury Auto Accident Other (**please explain**): _____

Date of injury/accident/other: _____ *If Worker's Compensation, please supply a copy of authorization and billing information.

INSURANCE INFORMATION (Patient informed to contact insurance company for benefit/coverage verification on _____)

Insurance Co.: _____ Phone #: _____ Fax #: _____

Address: _____ City, State, Zip: _____

Insured's Name: _____ Relationship: _____ Policy #: _____ Group #: _____

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL

I give my consent and authorization for the medical or billing staff of Integrated Therapy Practice, PC to leave protected health care information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand that I may revoke this privilege at any time by submitting my request in writing to retrieve results of all tests and procedures.

Phone Number: _____ Signature: _____ Date: _____

Restriction(s): _____

Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of the **NOTICE OF PRIVACY PRACTICE**. Initial: _____ Date: _____

(YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM)



The patient presented for his/her physical therapy evaluation/treatment and was provided with a copy of the ASC's Privacy Notice. A good faith effort was made to obtain a written acknowledgement of receipt; however, an acknowledgement was not obtained due to:

- Patient's refusal to sign.
- Patient being unable to sign or initial because: _____
- A medical emergency (the ASC will attempt to obtain a signed acknowledgement at the next available opportunity.)
- Other reason, Please describe: _____

Signature of employee completing form: _____ Date: _____

**CONSENT FOR TREATMENT & RELEASE OF INFORMATION
INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS**

(Please read and sign below)

I authorize Integrated Therapy Practice, PC to deposit checks received on my account when made out to me. I understand that if the insurance company sends payment directly to me, I am **RESPONSIBLE** for turning payment over to **Integrated Therapy Practice, PC** upon receipt of the check. Failure to do so will result in me being responsible for the total balance due on the account in full. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES, COSTS, AND FEES INCURRED DURING MY EVALUATION AND TREATMENT PROGRAM AT INTEGRATED THERAPY PRACTICE, PC NOT COVERED BY MY INSURANCE CARRIER(S). IN THE CASE OF NO INSURANCE COVERAGE, I AM RESPONSIBLE FOR PAYMENT IN FULL.** If I am unable to pay the balance in full, it is my responsibility to make financial arrangements and make regular payments on my account balance until paid in full. Furthermore, I understand that all delinquent accounts are turned over for collection to a third party agency if no payment is received for 75 days. This agency does report to all credit bureaus for recording on personal credit history. If I fail to pay for these services, I agree to pay the collection agency fees, attorney fees, and court costs incurred in collecting the debt. **I consent to the above billing procedures as confirmed by my signature below.**

I have, or my child (ward) has, a condition for which a licensed physician has prescribed physical therapy as a part of my treatment plan. I request and consent to **INTEGRATED THERAPY PRACTICE, PC** and its physical therapists, assistants, and professional staff to perform therapeutic procedures that may be necessary for my rehabilitative treatment as necessary and desirable in the exercise of professional judgment. It is not possible to make guarantees concerning the results of this or any treatment. I acknowledge that no such guarantees have been made to me. I consent and agree to have digital photographs taken prior to and after treatment. This release gives **INTEGRATED THERAPY PRACTICE, PC** the right to use the photographs in conjunction with the evaluation of the effectiveness of treatment and/or research purposes. I also authorize **INTEGRATED THERAPY PRACTICE, PC** to obtain and release any medical information, verbal or written, necessary to provide appropriate patient care. I understand that all information exchanged is maintained under the **INTEGRATED THERAPY PRACTICE, PC** Confidentiality Policy.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

PRACTICE GUIDELINES

(Please read our guidelines; and once you have completed this, please sign at the designated area.)

- Appointments are scheduled for 2-week increments only. Also, it is the patient's responsibility to maintain their schedule and confirm their next appointment at each visit.
- Our "missed appointment policy" is as follows: If you have two missed appointments in a row or show a pattern of various missed appointments, you will then be scheduled on a week-by-week basis and not front-loaded with appointments in 2-week increments.
- If you must cancel an appointment, please let our office know 24 hours in advance so that another patient may benefit.

If you have any questions, please feel free to ask.

Integrated Therapy Practice, PC

Date: _____ **Patient Signature:** _____