Integrated Therapy Practice P.C.

WELCOME TO OUR OFFICE

We appreciate the confidence and trust that you have placed in us. As a patient, you can expect one-on-one care with one of our licensed professionals. Integrated Therapy Practice was founded on one principle – **EACH PATIENT IS UNIQUE;** therefore, it is our responsibility and commitment to give you the individualized care that you deserve.

PLEASE BE ADVISED OF THE FOLLOWING PRACTICE GUIDELINES:

- Appointments will be scheduled in two-week increments. It is your responsibility to maintain your schedule and confirm appointments at each visit.
- Co-pays must be paid at the time services are rendered.
- It is your responsibility to check your insurance benefits. The receptionist will obtain a quote of benefits as a courtesy, but it is ultimately that patient's responsibility to check his/her benefits.
- Please inform our staff if your visit pertains to an auto accident or workman's compensation.
- If you have MEDICARE and you are receiving ANY services in your home that Medicare pays for or if you are receiving or have received (during this year) any other physical therapy or speech therapy, you must notify our receptionist PRIOR to being seen by our physical therapist.
- There will be a **$35 CHARGE** for any no-show appointments and cancellations made without a 24-hour notice.
- Please be sure to advise your therapist of any and all upcoming doctor appointments so that we can update their office on your care and progress.

THANK YOU FOR CHOOSING INTEGRATED THERAPY PRACTICE FOR YOUR THERAPY NEEDS. WE LOOK FORWARD TO WORKING WITH YOU.

Date: _____ Patient Signature: _____

1265 S Lake Park Ave. • Hobart, IN. 46342 • (219) 945-1538 • Fax (219) 945-0151
521 E. 86th Ave., Suite J • Merrillville, IN. 46410 • (219) 736-2801 • Fax (219) 736-2901
660 Morthland Drive (US 30), Suite D • Valparaiso, IN. 46385 • (219) 531-1756 • Fax (219) 531-1759
3108 Santa Barbara Blvd, Suite 108 • Cape Coral, FL. 33914 • (239) 257-1431 • Fax (239) 257-1485

Patient Financial Responsibility Policy

- I understand that it is my responsibility to provide the office of Integrated Therapy Practice with current, accurate billing information at the time of check in and to notify Integrated Therapy Practice of any changes in this information.

- I understand that it is my responsibility to know my **Specialist co-pay** (which can be different than my Primary Care co-payment) and to pay it at time of services. I understand that this is a contractual agreement that I have with my health plan and that Integrated Therapy Practice also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay co-pay.

- I understand that if I present an insufficient funds check (NFS check) for payment on my account that I will be charged a $25.00 NFS Fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

- If I do not show up for a scheduled appointment and did not cancel within 24 business hours I will be charged $35.00 for each appointment I miss.

- I understand that Integrated Therapy Practice will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any outpatient Physical Therapy appointments. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE BASED ON 1) Anticipated therapy to be performed and 2) current information provided to Integrated Therapy Practice by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I further understand that it is the policy to collect/bill for deductible and/or coinsurance balances as indicated on the statements/EOB from insurance companies.

- I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with the collection efforts.

- I understand that Integrated Therapy Practice will obtain the necessary prior authorization to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and I am responsible with collection efforts.

- I understand that Integrated Therapy Practice may also take a verbal request to use my credit card for payment on my account.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Integrated Therapy Practice.

I authorize Integrated Therapy Practice to release pertinent medical information to my insurance company when requested, or facilitate payment of claim.

Patient Name: _____ Date: _____
(Please Print)

Patient Signature: _____

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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) _____ **SPOUSE/RESP. PARTY BIRTHDATE:**_____

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)

- ○ 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:** _____

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MEDICAL INFORMATION

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, we'll be happy to assist you. Thank You!

NAME_____ **AGE**_____ **DOB**_____
OCCUPATION_____ **LEISURE ACTIVITIES**_____

Please circle any of the following medical professionals you are currently seeing**:**
Medical Doctor Osteopath Psychiatrist/Psychologist Physical therapist Chiropractor Dentist

If you have been seen by any of the above during the last three months, please describe for what reason (illness, medical condition, physical examination, etc.)

_____
_____
_____

Please circle any of the following conditions that you have EVER been diagnosed with and describe below:
High / Low Blood Pressure Heart problems Thyroid problems Diabetes Emphysema Asthma

Chemical dependency Alcoholism Multiple sclerosis Hepatitis Depression Stroke

Rheumatoid arthritis Tuberculosis Kidney disease Anemia Epilepsy AIDS

Other Arthritic conditions Cancer Other

_____
_____
_____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	**SURGERY / HOSPITALIZATION / REASON**
_____	_____
_____	_____
_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	**INJURY**
_____	_____
_____	_____

Please circle the conditions below that anyone in your immediate family (parents, brothers, sisters) have ever been treated for?
High / Low Blood Pressure Heart disease Kidney disease Diabetes Chemical dependency

Alcoholism Kidney disease Tuberculosis Epilepsy Mental illness

Arthritis Headaches Stroke Anemia Cancer

(Please turn over and complete questions on back)

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Crown Point: 11450 S. Broadway • Crown Point, IN 46307 • 219.488.0157 Fax 219.661.2502

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Please circle the following **OVER-THE-COUNTER** medications you have taken in the last week.

Advil Motrin Ibuprofen Aspirin Tylenol Decongestants

Vitamins Mineral supplements Antacids Laxatives Antihistamines Other:_____

Please list any **PRESCRIPTION** medication you are currently taking (including pills, injections, and/or skin patches):

_____

_____

How much caffeinated coffee or other caffeine containing beverages do you drink per day?_____

How many packs of cigarettes do you smoke a day?_____
How many days per week do you drink alcohol?_____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting?_____

How many days per week do you use marijuana?_____
How many days per week do you use drugs such as cocaine, crack, acid, etc.?_____

Please list any DRUG, FOOD, SEASONAL, or PRODUCT allergies:

_____

_____

Is there anything else you would like for us to know? (If yes please explain)_____

_____

_____

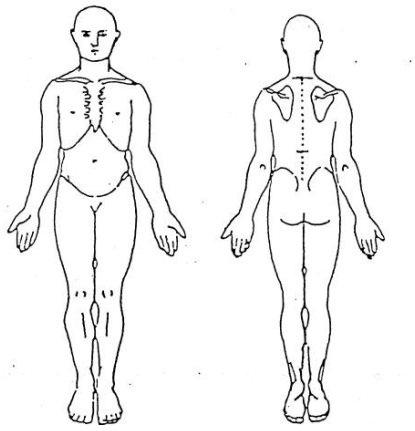
_____ _____
(Patient/Guardian Signature) (Date)

Please circle either the correct answer to the question below:

Have you currently experienced:

1. **YES NO** Weight loss / gain
2. **YES NO** Nausea / vomiting
3. **YES NO** Fatigue
4. **YES NO** Weakness
5. **YES NO** Fever / Chills / Sweats
6. **YES NO** Numbness or tingling

On the illustration below please identify areas of pain with an "**X**" and areas of numbness with an **"O".**



*_____Date_____
(Patient / Guardian Signature)

For office use only

Reviewed by:_____ Date:_____

Notes: