Patient Information

Last Name_____ First Name _____MI_____

Address_____Apt_____

City_____State_____Zip_____

Home Phone_____ Cell Phone _____Work Phone_____

Date of Birth_____ Gender_____ Marital Status_____

Email_____

Referring Physician

Name_____

Phone_____

Primary Care Physician

Name_____

Phone _____

Emergency Contact Information

I, _____, give my permission to Integrative Physical Therapy to release: 1) date and time of appointments, 2) account information, and 3) medical records to the individuals listed below. Even if you choose to leave this segment blank, please sign and date at the bottom.

1)_____ _____ _____
Name Relationship to Patient Phone Number

2)_____ _____ _____
Name Relationship to Patient Phone Number

Medication Verification Form Please list all medications including over the counter medications and supplements.

Medication	Dosage	Frequency

_____ _____
Patient Signature Date

_____
Print Name

INTEGRATIVE PHYSICAL THERAPY

CONSENT FOR TREATMENT / RELEASE OF INFORMATION / HIPAA PRIVACY NOTICE / FINANCIAL AGREEMENT

Patient Name: _____ **Date:** _____

CONSENT: My representative or I, recognizing the need for care, consent to all services rendered by Integrative Physical Therapy and ordered or deemed appropriate by my physician and/or physical therapist.

Initial here_____.

HIPAA PRIVACY NOTICE: I acknowledge that I have received the HIPAA Privacy Notice and have had the opportunity to review its content.

Initial here. _____

FINANCIAL POLICY STATEMENT: Integrative Physical Therapy does not participate in third party insurance plans therefore payment is due at the time of service. The charges incurred may be eligible for out of network benefits and codes will be available to you if you wish to file these charges with your insurance company or with a HSA or FSA account. If you wish to receive these codes please initial below.

Initial here_____

Integrative Physical Therapy does not have agreements with third party payers and therefore will not routinely provide additional information to your insurance company. In the rare event that more information is required to process your claim, please initial the following paragraph.

RELEASE OF INFORMATION: I agree that **Integrative Physical Therapy,** at my direction, may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health.

While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS YOUR PHI and/or BILLING INFORMATION.

Name: _____ Relationship _____ PHI _____ Billing _____

Name: _____ Relationship _____ PHI _____ Billing _____

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient/Guardian/Responsible Party **Date**

Patient Health History

To ensure you receive a complete and through evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

NAME_____
LEISURE ACTIVITIES_____
OCCUPATION_____

ALLERGIES: List any medication(s) you are allergic to: _____
_____

Are you latex sensitive? _____

List any other allergies we should know about:
_____
_____

Please check (√) any of the following whose care you are under:

___ Medical doctor ___Psychiatrist/ ___Other
___Osteopath Psychologist
___Dentist ___Physical Therapist
___Chiropractor

Date of last physical examination_____

If you have seen any of the above during the past 3 months, please describe the reason (e.g., illness, medical condition, physical):_____
_____
_____
_____

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer. If yes, what kind:_____
YES NO Heart problems. If yes, what kind?_____
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Stomach ulcers
YES NO Chemical dependency (e.g., alcoholism)
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritic conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease (If Yes, what kind_____)
YES NO Blood clots
YES NO Osteoporosis
YES NO Other:_____

During the past month have you been feeling down, depressed, or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home or has anyone hit you are tried to injure you in any way? YES NO

Have you ever been threatened, hurt, or made to feel afraid or humiliated by your partner or someone close to you? YES NO

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

SURGERIES/HOSPITALIZATIONS
(INCLUDE DATE AND REASON)

1._____
2._____
3._____
4._____
5._____
6._____

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

DATE INJURY
1._____
2._____
3._____
4._____
5_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Heart disease
YES NO High blood pressure
YES NO Stroke
YES NO Inflammatory arthritis
YES NO Cancer
YES NO Alcoholism (Chemical dependency)
YES NO Kidney disease

Which of the following do you use?

YES NO Tobacco How much?
YES NO Caffeine How much?
YES NO Alcohol How much?

Please circle any of the following that are NEW, UNUSUAL, OR ATYPICAL for you.

YES NO Weight loos/gain
YES NO Nausea/vomiting

YES NO Dizziness/lightheadedness
YES NO Fatigue
YES NO Weakness
YES NO Fever/chills/sweats
YES NO Numbness or tingling
YES NO Tremors
YES NO Seizures
YES NO Double vision
YES NO Loss of vision
YES NO Eye redness
YES NO Skin rash
YES NO Problems sleeping
YES NO Sexual difficulties
YES NO Night sweats
YES NO Hearing problems
YES NO Recently fallen down
YES NO Joint muscle swelling
YES NO Easy bruising
YES NO Excessive bleeding
YES NO Difficulty breathing
YES NO Regular cough
YES NO Arm/leg swelling
YES NO Heart racing in your chest
YES NO Difficulty swallowing
YES NO Heartburn/indigestion
YES NO Constipation/diarrhea
YES NO Blood in stools

_____

PATIENT SIGNATURE DATE

_____

THERAPIST SIGNATURE DATE