INTEGRATIVE
PHYSICAL THERAPY AND SPINE TREATMENT CENTER, INC

PATIENT INFORMATION:

Patient Name (*print*): _____
Responsible Party (if a minor): _____Relationship to patient: _____
E-mail address_____
*Emergency contact? _____ Tel #: _____

Patient Birth Date: ___ /___ /____ Sex: F ☐ / M ☐ Age: ____
Social Security #: _____-____-_____

Home/Mailing Address: _____
City: _____ State: _____ Zip: _____

I authorize Integrative Physical Therapy to call and leave a message at the following numbers:
Home: _____Cell: _____Work: _____

BILLING INFORMATION: Please indicate who we are billing for these services.

Insurance: (please bring or provide a copy of your plan card or authorization letter if applicable)
Primary insurance**:** _____
Secondary insurance**:** _____
Patient is: ☐ the insured. ☐ The dependent – Insured name:_____

Workman's Comp: Is this work related? Yes ☐ No ☐
Car accident? Yes ☐ No ☐
Accident/Injury date: ___-___-_____Claim #_____
Adjuster/Attorney: _____Contact Info:_____

Other (payment) or **comments**:_____
_____
_____

I certify that the information provided above is truthful and accurate: X_____
Print:_____

CONSENT FOR TREATMENT AND PAYMENT:

I understand that treatments administered to me by the staff of Integrative Physical Therapy And Spine Treatment Center, Inc. (IPT), while having the purpose of decreasing pain and improving function, may cause side effects including, but not limited to: soreness, stiffness, and fatigue, or other unforeseen outcomes. I further understand that failure to comply with treatment recommendations or instructions given to me by the IPT staff relating to my treatment or follow-up care may affect my treatment outcome. Although every effort will be made to maximize my progress while a patient at IPT, I do understand that it is impossible to predict or control the outcome in every treatment situation. I authorize this treatment and understand there is no guarantee of results.

Signature of Responsible Party (if other than patient) **Date**

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize Integrative Physical Therapy And Spine Treatment Center, Inc. (IPT), to release any medical records required/requested by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to 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 previsions. We will do our best, however***, it is not our responsibility to monitor your plans dollar or visit maximums.*** This is your (the patient's) responsibility. We encourage you to verify your own benefits as well. I understand that I will be responsible for any amount not covered by insurance or third party payer (such as Medicaid, Medicare or other Insurance Company) and that the balance is due upon receipt. All accounts that have not been paid in full within 120 days will be turned over to a collection company, Cornerstone Credit Services, LLC. We have a $35.00 returned check fee for all returned checks. 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 remaining balance is ultimately the patients' responsibility***. I understand and accept these conditions and terms.

Authorized Signature of Subscriber/Patient **Date**

Office Policy

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. As experienced specialists we will continually strive to provide you with individualized attention as well as attempt to satisfy your expectations and maximize your progress. Please be aware that we will accommodate your schedule on a "first come first serve basis". We do ask that patients not currently working be flexible in scheduling in the appointments during the mid-morning and mid afternoon. This allows working patient's access to morning, lunch 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 also detrimental 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 than 10 minutes late, we may need to reschedule your appointment. If you're here as scheduled and we do not initiate your treatment on time, you will receive full treatment. Repeated cancellations and/or failure to comply with treatment will result in discontinuation of care.

Signature of Patient **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 1966 (HIPAA) for your review. Our practice is complying with HIPAA's regulations and would be happy to answer any questions you might have.

- 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 indentify 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 operation 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, 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 the PHI for our practice's business planning and internal management activities.

  I understand the 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 contacting Integrative Physical Therapy and Spine Treatment Center, Inc.

  My signature below constitutes my acknowledgement that I have been provided with this 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

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Past Medical History Survey

Patient Name: _____ Date: ___/___/___

Referring Physician:_____

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.

Do you have any history of the following?

	Yes	No
High blood pressure	○	○
Circulatory problems	○	○
Heart trouble	○	○
Pacemaker	○	○
Epilepsy	○	○
Diabetes	○	○
Pregnancy	○	○
Blackouts	○	○
Visual disturbances	○	○
Headaches	○	○
Weight change (more than 15 lbs)	○	○
Respiratory ailment	○	○
Ringing in ears	○	○
Bowel or bladder	○	○
Malignancy	○	○
Stroke	○	○
Aneurysm	○	○
Pelvic	○	○
Tail bone injuries	○	○
	○	○

Please advise of any know allergies: _____
_____

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

_____

MEDICATIONS: Please list any medications that you are currently taking.

_____
_____
_____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity		Quite a Bit of Difficulty		Moderate Difficulty		A Little Bit of Difficulty		No Difficulty	
1	Any of your usual work, housework, or school activities.	0		1		2		3		4	
2	Your usual hobbies, re creational or sporting activities.	0		1		2		3		4	
3	Getting into or out of the bath.	0		1		2		3		4	
4	Walking between rooms.	0		1		2		3		4	
5	Putting on your shoes or socks.	0		1		2		3		4	
6	Squatting.	0		1		2		3		4	
7	Lifting an object, like a bag of groceries from the floor.	0		1		2		3		4	
8	Performing light activities around your home.	0		1		2		3		4	
9	Performing heavy activities around your home.	0		1		2		3		4	
10	Getting into or out of a car.	0		1		2		3		4	
11	Walking 2 blocks.	0		1		2		3		4	
12	Walking a mile.	0		1		2		3		4	
13	Going up or down 10 stairs (about 1 flight of stairs).	0		1		2		3		4	
14	Standing for 1 hour.	0		1		2		3		4	
15	Sitting for 1 hour.	0		1		2		3		4	
16	Running on even ground.	0		1		2		3		4	
17	Running on uneven ground.	0		1		2		3		4	
18	Making sharp turns while running fast.	0		1		2		3		4	
19	Hopping.	0		1		2		3		4	
20	Rolling over in bed.	0		1		2		3		4	
	Column Totals:										

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses to ACN.

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