

# INTEGRATED PHYSICAL THERAPY

## a whole-istic approach to physical therapy

Patient's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Business #: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referring Physician? \_\_\_\_\_

How do you hear about us: Dr. Referral - Friend Referral - Magazine - Other \_\_\_\_\_

### Diagnosis Information

Primary \_\_\_\_\_ Secondary \_\_\_\_\_

What are the problems you are experiencing: \_\_\_\_\_

### Insurance Information

Name of Insurance \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Member Services Phone # \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

### Secondary Insurance Information

Name of Insurance \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

### Assignment and Release

I, the undersigned, certify that I (or my dependent) has insurance as stated above and assign directly to Integrated Physical Therapy all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize IPT to release all information necessary to secure the payment of benefits. I allow fax transmittal of Medical records if necessary. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and/or Health Insurance Company.

- I consent to the treatment necessary for the care of the above named patient/client.
- I acknowledge full financial responsibility for services rendered by Integrated Physical Therapy and their staff and understand that the payment of charges incurred is due at the time of the service.
- I have read and fully understand the consent to treat, financial responsibility, and release of medical records information.

Responsible Party's Signature

Relationship

Date

2106 NE 123<sup>rd</sup> Street | North Miami, FL 33181  
305 967-8976 - phone | 305 967-8863 - fax | info@IPTmiami.com

**Integrated  
Physical  
Therapy**



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### Office Policies:

We are dedicated to providing highly individualized care for patients. Insurance companies will not dictate the care you receive at IPT. Your plan of care is achieved through the professional assessment of your therapist and is based on your specific functional goals. Please read the following policies and sign below:

1. **Insurance:** In order to maintain our high standard of care IPT does not participate in network with insurance plans. We do accept all out of network policies depending on if your insurance policy has an out of network benefit. Please make sure that we have all your current insurance information.
2. ***Please be aware that your insurance company may only cover a portion of your service. You, the client/patient will be responsible for the difference.***
3. **Medicare:** IPT is a participating provider for Government Medicare. IPT will bill Medicare directly. The Client/Patient is responsible for any deductible remaining at the time of service. Be aware, there is a cap/maximum allowable amount on all Medicare allowable claims.
4. **Worker's Compensation:** Worker's Compensation claims will be submitted directly by our office or a billing company directly associated with our office. Please make sure that we have all your current insurance information – including your claim number, date of injury, the name and telephone number of your claim's adjuster, and the correct address to where we should mail the claims.
5. **Myofascial Release/Massage/Pilates/Personal Training:** All services under Myofascial Release, Massage, Pilates or Personal Training are paid in full at the time of service. IPT does not bill insurance for these services **unless** these services are rendered as a part of skilled physical therapy.
6. **Automobile Accidents:** IPT will bill your Auto Insurance only under PIP benefits. IPT will not accept assignment on any automobile accident. We do not accept settlement from attorneys or wait for settlement from any automobile carriers.
7. **Durable Medical Equipment (DME) and Supplies:** DMS and Supplies are not reimbursable by insurance companies and must be paid for at the time you receive such equipment.
8. **Payment:** payment is expected when services are rendered (each visit). For your convenience, we accept checks, cash, Visa, and Master Card.
9. **Late Charges/Returned Checks:** Any account that remains open beyond 30 days from the last date of service will be subject to a \$10.00 fee for each month that the account is not paid in full. There is a \$35.00 fee for all returned checks.
10. **Cancelled/Missed Appointments:** Late arrivals are subject to the full fee for the session. We require 24 hours notice for all cancellations. All appointments that are cancelled within less than 24 hours notice or "no-show" are subject to the full fee for the session. With 2 missed appointments, either cancelation or no-show, IPT reserves the right to cancel all remaining appointments.
11. **Fees:** Initial Evaluations are \$220 and last approximately 60 min. Subsequent sessions are billed at \$200 and are typically 1 hour. Please remember the therapist reserves the right to treat the patient for 50 minutes leaving 10 minutes for the required paperwork and documentation for the visit. Please inquire about discounted pricing.

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**Consent for Treatment:** The patient hereby consents to the administration of appropriate evaluation and therapeutic treatment/procedures as requested by the patient and/or physician prescribing care. Or, in the case of fitness or treatment provided by a therapist or fitness staff member under the heading of wellness or fitness.

**Our Pledge Regarding Medical Information:** We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at IPT. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by IPT. We are required by law to:

- a. Make sure that medial information that identifies you is kept private
- b. Give you this notice of our legal duties and privacy practices with respect to medical information about you.

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I have read the above polices and understand that payment is due when services are rendered. I agree to accept full financial responsibility for expenses incurred at Integrated Physical Therapy.

If Patient/Client is under 18 years of age, and a parent is not available to attend sessions of Physical Therapy with the minor, the Parent(s) signature for authorization allows IPT to commence Physical Therapy or fitness treatments with the patient who is a minor. The parent(s) is also accepting full financial responsibility for the treatment.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date: \_\_\_\_\_

(If patient/Client is under 18 y/o)



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### **Integrated Physical Therapy Financial Policy**

In order to maintain our high standard of care and individualized treatment sessions, IPT does not contract with insurance plans. However IPT is an out-of-network provider for all insurance plans.

We are a participating provider for government supplied Medicare.

#### **Our guarantee to you:**

- Your plan of care will be based on the professional assessment of your physical therapist and physician.
- Insurance companies will not dictate the care you receive
- Functional goals will be established to meet your specific needs

#### **Billing:**

- Payment is expected when services are rendered.
- The patient is responsible for all charges for services provided by IPT.

#### **Cancelled/Missed Appointments:**

- Late arrivals are subject to the full fee for the session. We require 24 hours notice for all cancellations. All appointments that are cancelled within less than 24 hours notice or “no-show” are subject to the full fee for the session. With 2 missed appointments, either cancelation or no-show, IPT reserves the right to cancel all remaining appointments.

#### **Courtesy Option:**

If insurance was pre-verified by IPT we will submit your insurance claim.

- Verification is not a guarantee of payment by the insurance company. The patient is responsible for knowing benefit knowledge of his or her own insurance and is responsible for all payment of services.

I have read Integrated Physical Therapy's Financial Policy and understand that the patient is ultimately responsible for all charges for services provided by IPT.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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