INTEGRATED PHYSICAL THERAPY
A Holistic Approach to Physical Therapy

Name: _____D.O.B.: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell #: _____

Business #:_____ Social Security Number: _____

E-mail Address: _____

Height: _____ Weight: _____

Referring Physician? _____

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

Diagnosis Information

Primary_____ Secondary_____

Assignment and Release

I, the undersigned, agree that Integrated Physical Therapy is a **non-participating provider** with any and all insurance networks. If you choose to submit for reimbursement from your insurance company, you can do so **on your own**. IPT will provide such details including documentation, diagnosis codes and a packet explaining how to submit for re-imbursement on your own. If you require IPT staff to assist you, (such as itemized bills) there will be a $30.00 per hour charge.

I understand that I am financially responsible for all charges whether or not reimbursed 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

2142 NE 123rd Street - North Miami, FL 33181
1117 E. Hallandale Beach Blvd. - Hallandale Beach FL 33009
305 967-8976 - phone 305 967-8863 - fax info@IPTmiami.com

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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 medical 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.

Patient Signature_____ Date: _____

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.

Parent's Signature_____ Date: _____
(If patient/Client is under 18 y/o)

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Patient Profile

BRIEFLY DESCRIBE HOW YOU WERE INJURED – Why are you here today:

_____

_____

PLEASE DECRIBE ANY PAST TAUMA/INJURY OR SURGERY:

_____

_____

PREVIOUS CARE YOU HAVE RECEIVED (physical therapy, acupuncture, injections, etc)

_____

_____

_____

_____

HAS YOUR CONDITION BEEN GETTING: ☐ WORSE ☐ SAME ☐ BETTER

ARE YOUR SYMPTOMS: ☐ CONSTANT OR ☐ INTERMITTENT

MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

0=NO PAIN, 10=EXCRUCIATING PAIN

AT BEST: 0 1 2 3 4 5 6 7 8 9 10 - AT WORST: 0 1 2 3 4 5 6 7 8 9 10

MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR STIFFNESS:

0=NO STIFFNESS, 10=A LOT OF STIFFNESS

AT BEST: 0 1 2 3 4 5 6 7 8 9 10 - AT WORST: 0 1 2 3 4 5 6 7 8 9 10

WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

	Bending		Rest		Sitting		Standing		Rising
	Movement		Better in the AM		Better in the PM		Walking		Prolonged Positions
	Ice		Heat		With Meds		Changing Positions		Other

WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

	Bending		Rest		Sitting		Standing		Rising
	Movement		Better in the AM		Better in the PM		Walking		Prolonged Positions
	Ice		Heat		With Meds		Changing Positions		Other

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PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

	X-Ray		MRI		CT Scan		Injection		Other_____

What are your goals for therapy? _____

_____

At the present time, would you rate your overall general health as?

___ excellent ___ good ___fair or ___ poor?

We believe in an integrated, holistic, whole-body approach. Therefore, the following information is being requested to aide us in providing you with the most informed care and highest quality of service.

Have you ever had the following?

Yes/No	High blood pressure
Yes/No	Heart disorder
Yes/No	High cholesterol
Yes/No	Lung disorder
Yes/No	Depression
Yes/No	Chronic fatigue
Yes/No	Pacemaker
Yes/No	Allergies to lotions
Yes/No	Diabetes
Yes/No	Anxiety disorder
Yes/No	Incontinence
Yes/No	Stroke

Yes/No	Arthritis
Yes/No	Circulation disorder
Yes/No	Dizzy spell
Yes/No	Seizures
Yes/No	Chronic pain
Yes/No	Fibromyalgia
Yes/No	Cancer
Yes/No	Osteoporosis
Yes/No	Are you pregnant?
Yes/No	Gastrointestinal disorder
Yes/No	Headaches
Yes/No	Neurologic disorder

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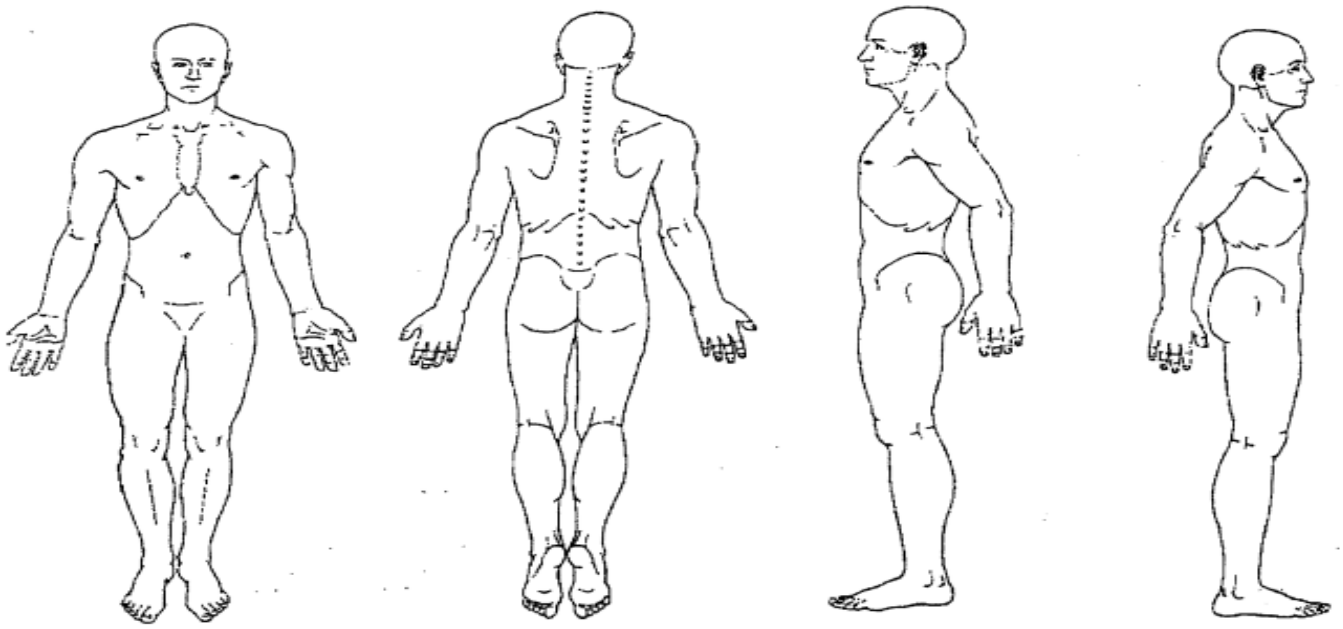
Pain Diagram

Name: _____ **Date:** _____



PLEASE CIRCLE WHERE YOU ARE HAVING PAIN.

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for taking	Date Started	Prescriber

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Please initial next to each statement.

____ I consent to undergo all necessary physical therapy, acupuncture, massage or functional exercise treatments and procedures known to improve my condition by the staff of IPT.

____ I have been or will be introduced to the Physical Therapists or other staff members including acupuncturist, massage therapist or other professionals who may be a part of my care here at IPT.

____ I am aware that the practice of Physical Therapy, massage therapist, acupuncture is not an exact science, and I acknowledge that no guarantees have been made as to the results of my condition and physical performance status.

____ I authorize Integrated Physical Therapy and Wellness to take still photographs and video for treatment and educational purposes as they wish. Any phots or video used for educational or research purposes, will not reveal, where possible my identity through the image itself or in the accompanying text.

____ I consent to the release of my medical information and records to other health care providers and physicians, this being necessary for the purpose of diagnosis and collaborative treatment.

____ I authorize payment directly to Integrated Physical Therapy and Wellness. I agree that a scanned or faxed copy or transmission of this authorization is valid as the original.

It is Florida State law that you provide a current prescription for your treatment with in 10 visits or 30 days of your first visit. We need your help in securing a new prescription from your doctor if your treatment lasts more than 30 days or 10 visits. Please ask your therapist for the renewal date of your prescription so that we can insure continuity of treatment.

I am fully aware of my diagnosis and prognosis and I consent to treatment by Integrated Physical Therapy and Wellness.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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CANCELATIONS: Cancelations must be made at least 24 hours in advance to avoid being charged for your session. Calling 24 hours in advance allows us to place another person
Waiting to be seen. Failure to show up or call will result in a **FULL charge**. With 2 missed appointments, either cancelation or no-show, IPT reserves the right to cancel all remaining appointments.

LATE POLICY: You will be seen for the time you are scheduled. If you arrive late, you will be charged the full session time.

SCHEDULING: Therapy sessions are scheduled based on the client's request and the therapist's availability. Multiple (2) cancelations of scheduled therapy sessions will result in forfeiture of preferred time slot.

Integrated Physical Therapy **does not** participate with any insurance company and **Will Not** bill your insurance company for you. You CAN submit to your insurance company on your own and IPT will provide the information needed for reimbursement such as diagnosis codes, and documentation. If you require IPT's professional staff to help you submit to your insurance, there will be a $30.00 per hour charge.

Fees:

Carol Davis - MFR	$260.00/$225.00
Craig Cohen - MFR/PT	$175.00
Tara Carrington - MFR	$175.00
Staff Therapists/Sports Medicine	$150.00
Susan Farkas – Nutrition	$120.00/$100.00
Andrea Orvieto - Acupuncture	$125.00/$90.00
Massage	$90.00
Pilates	$90.00

Packages are available - please ask for details
Packages are non-transferable between clients and services

PAYMENT:
- Initial Evaluation prices are to be paid on the day of the consult
- Follow up visits can be paid per visit or per credit card held on file at the time of the visit
- Cancelation/no show fees must be paid in full prior to your next scheduled visit
- Packages are prepaid and not transferable or refundable
- Credit cards, cash and checks are accepted

APPOINTMENT REMINDER
We will remind you of your next appointment 24 hours prior to your scheduled appointment.
Please indicate your preference.

Phone Call to _____

E-mail to _____

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INTEGRATED PHYSICAL THERAPY & WELLNESS

Where Health and Wellness Meet Mind and Body

The purpose of this reservation form is to allow us to serve you in the best way possible. When you schedule an appointment at IPT, the time is reserved for you. Since we are reserving this spot just for you, please be conscious of your time and the therapists time.

Important Details:

- Cancellations made with less than 24-hour notice will result in a full charge
- No show patients will result in a full charge

If any changes occur, letting us know on time allows other clients to have the blissful opportunity for healing.

I _____ hereby authorize Integrated Physical Therapy to charge my credit card account in the full amount of my scheduled session in the event that I do not call to cancel or reschedule my appointment at least 24 hours in advance of my scheduled appointment or with prior notice.

CREDIT CARD INFORMATION

Credit Card # _____

Expiration Date _____ 3-digit CVV/AVS code _____

BILLING ADDRESS

Street _____

City _____ State_____ Zip Code_____

As the credit card holder, I hereby authorize this transaction.

APPOINTMENT REMINDER

We will remind you of your next appointment 24 hours prior to your scheduled appointment. Please indicate your preference:

Phone call to _____

Email to _____