INTEGRATED PHYSICAL THERAPY
A Holistic 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: _____ **Height:** _____ **Weight:** _____

Referring Physician? _____ Status: Married/Single/Other/Full time student/Employed

How do you hear about us: Dr. Referral/Friend Referral/Other _____ Smoker or Non Smoker? _____

Diagnosis Information

Primary_____ Secondary_____

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) have 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

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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Please read and initial all confirming that you understand and agree to the terms and conditions of our Policy.

____ **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, unless, you have a secondary insurance. If not, a 20% co-payment will be collected from you at the time service is rendered. Please be aware, there is a cap/maximum allowable amount on all Medicare allowable claims.

____ **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 as they are not coverable services under insurance coverage. Ask about our concierge therapy service.

____ **Insurance:** In order to maintain our high standard of care IPT does participate in most in-network insurance plans. In order for IPT to bill your insurance company, PRIOR TO YOUR FIRST VISIT, IPT must have a copy of the prescription from your doctor as well as all necessary authorizations from your insurance company. Without these, YOU MAY BE RESPONSIBLE FOR COVERAGE OF YOUR PHYSICAL THERAPY VISIT.

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.

____ **Payment:** (Co-pay or Co-insurance or Fee-For-Service) is expected upon arrival (each visit). For your convenience, we accept checks, Cash, American Express, Visa, and Master Card.

____ **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.

____ **CANCELLED/MISSED APPOINTMENTS:** Late arrivals are subject to the full fee for the Session. We require 24 hours' notice for all cancellations. Appointments that are cancelled within less than 24 hours' notice or "no-show" are subject to a **$50.00 fee** for the session. With 2 missed appointments, either cancelation or no-show, IPT reserves the right to cancel all remaining appointments. **Self-Pay/Cash clients who cancel within less than 24 hours' notice or no show for a session will be charged the full rate of $175.00/$125.00.**

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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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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.

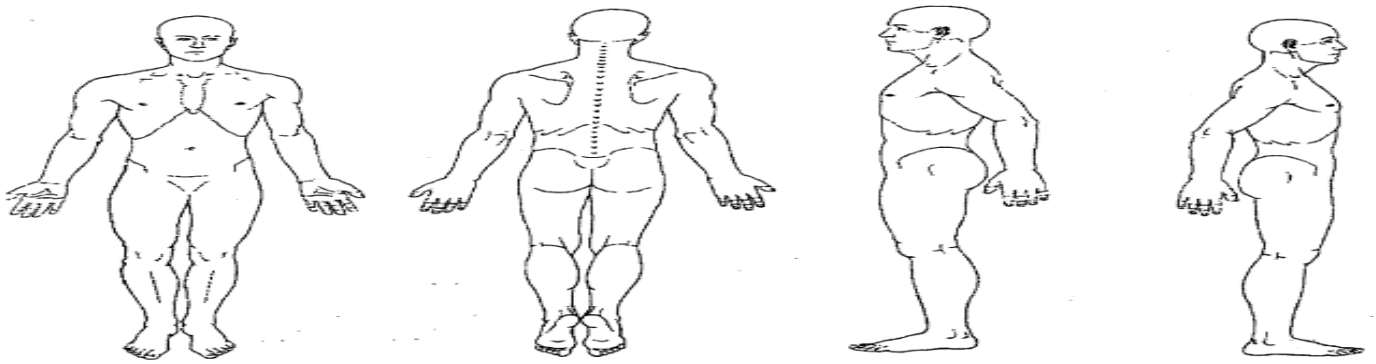
Have you ever had the following?

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

Pain Diagram

Name: _____ Date: _____



PLEASE CIRCLE WHERE YOU ARE HAVING PAIN.

Medication	Dosage	Frequency	Start date	Purpose	Prescribing doctor

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Are you in pain currently? Yes_____ No_____

Scar tissue can cause pain and dysfunction in the body. Please list all surgeries you have had, including cosmetic. _____

_____

What, if any, recent diagnostic studies have you had? (MRI, Doppler, X-ray, etc)

_____

History of current condition, including onset date.

_____
_____
_____
_____

Previous care you have received (physical therapy, chiropractic, acupuncture, injections, etc)

_____
_____
_____
_____

What are your goals for therapy? _____

_____

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

___ excellent ___ good ___fair or ___ poor?

Do you engage in regular physical activity? If yes, please describe.

_____
_____

Is there anything else you would like us to know?

_____
_____
_____

_____

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AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. Furthermore, I request that payment under the medical insurance program be made to me or to Integrated Physical Therapy. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize the holder of medical information about me to release it to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I understand that this is a lifetime signature authorization.

I request that payment of authorized MEDIGAP benefits be made on my behalf to Integrated Physical Therapy, for any services furnished me by (physician/supplier). I authorize any holder of medical information to release to Integrated Physical Therapy, any information needed to determine these benefits or the benefits payable for related services.

A. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I authorize Integrated Physical Therapy to release to your company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Medical or Surgical treatment or service by reason of such treatment of service.

B. FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges not covered by this authorization and for the guarantees stated above. Also, I understand that it is my responsibility as the insurance to pay all copayments and coinsurance at the time of the visit.

C. APPOINTMENT POLICY

I understand that I will be charged a fee **for appointments not canceled within 24 hours**. This includes canceled appointments, rescheduled appointments, and missed appointments ("no-shows"). Appointments may be canceled via telephone. **The fee is $50.00** but is subject to change at the discretion of Integrated Physical Therapy. **Self-Pay patients who do not cancel within 24 hours or "no show" to an appointment will be charged the full rate of the session that day $175.00 / $125.00.**

Please initial here _____

D. REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. If an authorization or referral is not obtained by the time of the visit, the visit will be rescheduled and considered a same-day cancellation, resulting in a fee. (SEE ABOVE)

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR IT'S REPRESENTATIVE.

Signature: _____ Date: _____

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