Integrative Physical Therapy, Inc.

4850 Goodman Rd Ste 110 Olive Branch, MS 38654
Ph. 662.349.6712 Fax 662.349.6782

PATIENT INFORMATION

NAME(last, first) _____

HOME ADDRESS _____ CITY_____STATE___ ZIP_____

SOCIAL SECURITY #_____ DATE OF BIRTH _____ AGE___ SEX_____

HOME #(____)_____ CELL # (____)_____ Preferred Contact # Home or Cell(circle)

Please send my appointment reminders to my Home or Cell via Voice Message or Text?(circle your choice on both)

EMPLOYER/OCCUPATION_____ WORK # _____

EMAIL _____ MARITAL STATUS S M W D SPOUSE'S NAME_____

EMERG. CONTACT _____ RELATIONSHIP _____ PHONE _____

Are you seeking treatment for an injury? ***Y or N*** *occur at home?* ***Y or N*** *occur at work?* ***Y or N***
auto accident? ***Y or N*** *Please provide date of injury and brief explanation*_____

Primary Insurance _____ Are you the subscriber of the policy? Y or N If no, please list the subscriber's full name and date of birth _____

Secondary Insurance _____ Are you the subscriber of the policy? Y or N If no, please list the subscriber's full name and date of birth _____

I hereby consent and authorize the administration of all procedures. I hereby authorize Integrative Physical Therapy, Inc. to release or obtain any information acquired in the course of my treatment to the insurance company, attorney, or referring physician.

I also assign and request that my medical insurance/automobile insurance carrier make payment directly to Integrative Physical Therapy, Inc. for medical services rendered to me. I understand that if the claims are denied or are not paid in a timely manner, I will be responsible. I understand that I am ultimately responsible for the balance of my account for any professional services rendered. In the event that your account becomes delinquent, you agree that we and our collection agency may contact you by phone, including your mobile, which could result in charges to you. We and our collection agency may also contact you by sending text messages or emails, using any email address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Signature of Responsible Party Date

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Welcome to Integrative Physical Therapy, A Myofascial Release Treatment Center

We would like to take this opportunity to thank you for choosing our facility; we look forward to assisting you in your healing process. We aim to provide the expertise, guidance, environment, and therapeutic treatment to help you achieve your goals and return to a pain-free, active lifestyle.

Myofascial Release is a whole body, hands-on treatment approach where therapy is applied directly on the skin without the use of lotions or oils. Because of this, the skin will need to be accessible as much as possible during the treatment session. **Please do not put any lotion on your skin prior to treatment**, as it makes it difficult to administer the myofascial release techniques. We suggest that clients wear loose fitting gym shorts and females wear a top that will unclasp in the back (such as a bra), swimsuit top, or sports bra.

A typical treatment session is approximately 1 hour long. However, your first visit will include a thorough evaluation and will last approximately 1 ½ hours. Photographs taken during the initial evaluation and re-evaluations will be used for postural comparison purposes and as education tools for postural awareness training. By signing below, you consent to the use of these photographs in a professional manner. Photos will not be sent to insurance or other providers unless you give written consent.

If you cannot adhere to a scheduled appointment, it is your responsibility to call the office to cancel within 24 hours of your appointment. A fee of $50.00 will be charged to your account if you fail to give 24 hours notice.

Please be advised that the insurance coverage for these services is dependent on the contract between you, your employer and/or the insurance company. We will contact your insurance company to determine what services are covered, the percentage of the coverage, and the contract limits of your plan. We will do our best to keep you informed, but ultimately you are responsible for understanding your coverage limits and will be held responsible for services or exercise equipment that is not covered by your insurance plan.

If we are out of the network for your current insurance provider, you have the option of filing your own insurance and receiving the services at a reduced fee. If you elect this option, payment is due at the time of service.

- ***I understand the above information and agree to pay the required balance or co-payment, according to the contract limits of my insurance plan. Accounts unpaid for 90 days will be submitted to a collection agency and a 30% service charge will be added to any account balances that are past due. You will be responsible for any and all cost of collection, including attorney fees and court cost.***

_____

Signature of Responsible Party Date

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Consent and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

This is a consent form. It asks you to permit us to use and disclose information about your health. I understand that as part of my health care, Integrative Physical Therapy, Inc. originates and maintains paper and/or electronic records describing my health history, examination, test results, symptoms, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning my care and therapy treatment.
- A means of communicating among the many health care professionals with contribute to my care.
- A source of information for applying my diagnosis and medical information to my bill.
- A means by which third party payers can verify that services were provided and properly billed.
- A means of obtaining payment from your insurance carrier and/or you, the client.
- And, a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

We have a "**Notice of Information Practices**" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent (please ask us for a copy if you want to review).
- The right to request restrictions as to how my health information may be used or disclosed to carry out therapy treatment, payment, or health care operations.

I understand that Integrative Physical Therapy, Inc. is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Integrative Physical Therapy, Inc. reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Integrative Physical Therapy, Inc. change their notice, they will send a copy of any revised notice to the address provided, by my requested means (U.S. mail, fax, or e-mail)

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

By signing below, I fully understand and accept the terms of this consent.

_____

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www.iptwellness.com

Cancellation Policy

Integrative Physical Therapy requires 24-hours notification if you are unable to keep your appointment. Patients who do not give adequate notice will be charged a **'cancellation/missed appointment fee' of $50 for that treatment session.** Payment or arrangement for payment must be made prior to additional appointments being made.

Please sign to indicate you understand our cancellation policy.

_____ _____

Signature Date