# Integrated Physical Therapy and Counseling
# Patient Registration Form

**Name:** (Last) ______________________________ (First) ________________________ (MI) ______

**Home address:** ________________________________________________________________________

City: ____________________________________ State: ___________ Zip________________

Home phone: ____________________________E-mail _______________________________

Cell phone: ______________________________

**Birth date:** ____________________ Sex: _________ Marital status: _____________

**Spouse's name:** _____________________________________

**Employer:** (If you are under 18, please list your parents' employers here and under Spouse employer.)

Company name: _________________________________________________________________

Address: ____________________________________________________ Zip ______________

Work phone: ______________________________Work fax: ____________________________

**Spouse's employer:** (If under 18, please list other parent's employer.)

Company name: _________________________________________________________________

Address: _____________________________________________________Zip ______________

Work phone: ______________________________Work fax: ____________________________

**Referring physician:** Name: ____________________________________________________________

Address: ____________________________________________________________

Phone: _______________________________Fax: _________________________

**Diagnosis** and/or description of problem: ____________________________________________________

____________________________________________________________________________________

Date of onset: _____________________________

Physical therapy is for treatment of (circle one): **Work injury / Auto accident / Other**

**Claim # (if applicable)** ________________________________

**Contact in case of emergency:** Name: ________________________________Relationship __________

Address: _________________________________________________________________

Phone: ________________________________

How did you hear about Integrated Physical Therapy: (circle best answer)

| | | |
|---|---|---|
| • Doctor | • Managed care plan or list | • Employer |
| • Friend or relative | • Yellow pages or phone book | • Other ____________________ |

**Signature:** _____________________________________________ **Date:** _______________________

Integrated Physical Therapy and Counseling

# Patient Health History

Name: ______________________________ Date: ________________________

Date of Birth: ____________________ Date of Last Physical: ________________

Present Complaint of Illness: ___________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Is this a recurring problem? _________________________________________________

Any recent surgery related to this condition? If yes, please give date and type of surgery.

_____________________________________________________________________________

Are you currently experiencing any of the following symptoms?

| | YES | NO |
|---|---|---|
| Headaches | ☐ | ☐ |
| Vertigo | ☐ | ☐ |
| Difficulty swallowing | ☐ | ☐ |
| Visual Disturbances | ☐ | ☐ |
| Nausea/ Vomiting | ☐ | ☐ |
| Breathing difficulty | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Blood in urine or stool | ☐ | ☐ |
| Neck pain | ☐ | ☐ |
| Abdominal Pain | ☐ | ☐ |
| Low back pain | ☐ | ☐ |
| Balance difficulty | ☐ | ☐ |
| Weakness | ☐ | ☐ |
| Loss of sensation | ☐ | ☐ |

Do you have, or have had in the past, any of the following conditions:

| | YES | NO |
|---|---|---|
| High Blood Pressure | ☐ | ☐ |
| Cardiac Problems | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Thyroid Conditions | ☐ | ☐ |
| Joint Replacements | ☐ | ☐ |

If you have answered “yes” to any of the above conditions, please explain.

________________________________

________________________________

________________________________

________________________________

Please list the medications you are taking. ______________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Please list your recreational activities. ________________________________________

_____________________________________________________________________________

**Please write down one goal you would like to accomplish in physical therapy.**

_____________________________________________________________________________

__________________________________________ ________________

Signature Date

Revised 7/16

**Integrated Physical Therapy and Counseling**

## BILLING POLICY, RELEASE, AND AUTHORIZATION

*Integrated Physical Therapy and Counseling is a fee for service practice and payment is due at the time of services rendered. We will not have any relationship with your insurance carrier and will not release any information to them without a signed Release of Information. We will make every effort to support you in filing your own claims, but cannot guarantee amount or timeliness of reimbursement. If you are unsure as to your ability to self submit claims, please contact your insurance carrier.*

Signature: ______________________________ Date: _________________

Please be aware that some insurance companies require prior authorization for treatment. It is your responsibility to acquire this information as this may affect reimbursement. Insurance companies **may not** reimburse retroactively. _________

## CANCELLATION POLICY

This office requires 24 hour notice on all appointments. A charge will be imposed on all appointments not cancelled with at least 24 hours or on any missed appointments. **This charge is your responsibility and cannot be charged to your insurance company**. The payment for this charge is expected before your next scheduled visit.

Signature: ________________________________ Date: ________________

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*This form acknowledges that you have received Integrated Physical Therapy and Counseling's Notice of Privacy practices.*

I ____________________________________, have received the Notice of
(Patient's printed name)
Privacy Practices from Integrated Physical Therapy and Counseling.

Signature: ________________________________ Date: ________________

## GUIDELINES FOR PHYSICAL THERAPY REIMBURSEMENT AND TREATMENT

Integrated Physical Therapy is a multi-disciplinary practice. Though we are a physical therapy practice, we integrate massage therapy, Craniosacral therapy and mental health counseling within a holistic perspective on wellness. **If you have out of network benefits, you may submit for reimbursement. We do not process claims here and payment is expected at the time of treatment.**

- Please let us know on your first visit if you are planning to submit to your insurance company. We can discuss the specifics to your healthcare issues.

- **MEDICARE PATIENTS: You cannot submit claims to Medicare or secondary Insurance. You may only be seen here as a client for Craniosacral Therapy, Massage or Mental Health Counseling.**

- Please be aware that some insurance companies **require pre-authorization before** you begin treatment. Unfortunately, this can change anytime so please double-check your policy.

- If we use ***somato-emotional release*** or ***mental health counseling*** approaches, your visit is not reimbursable under physical therapy insurance. Therefore, ***if you want your visit to be 100% reimbursable, you must let us know before the treatment session***. Our skill is to create a unique therapeutic experience for you. Altering this approach to fit only into physical therapy may interfere with your maximum therapeutic benefit.

- If we are treating you for physical therapy, we must have a physician who agrees with the treatment plan and signs scripts for your diagnosis and treatment. This is a separate issue from reimbursement.

- In order to reimburse under physical therapy, we must have a physical therapy diagnosis. We can discuss this specifically with you.

- Most insurance companies will not pay for maintenance physical therapy. If this is your need, please check the requirements of your specific policy.

- Our approach to wellness is a process that gradually and slowly unwinds the restrictions that create pain and dysfunction. This process may take a long time especially as we increase time between visits. **Your policy may set limits on number of visits or length of time for treatment.** If you have questions, please contact your insurance carrier.

We will do everything we can to support you in the reimbursement process. We understand it can be frustrating. If you have questions, please don't hesitate to contact us.

Most importantly, IPT is committed to inclusivity. If you are committed to your wellness, we are committed to helping you get there. Should financial means ever be a reason for cessation of treatment, please talk to us. We offer many different payment options.

In Wellness,

DJ Horn and all at IPT Patient Signature:___________________________Date:__________