Patient Intake Form

Name _____ M / F DOB: _____

Address: _____ City_____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( )_____

E-mail_____

Physician's Name _____

Did he/she refer you to this facility? Y / N

Today's Date _____ Date of injury: _____

Is this related to a motor vehicle accident or a work related injury? Y / N

Have you been treated for this in the past? Y / N If yes, when and where:

_____

HEALTH INSURANCE COVERAGE

1. **Are you the subscriber for your health insurance? Y / N**
2. **If you are *not* the subscriber, please provide the following:**

    Subscriber Name_____
    Subscriber Date of Birth_____

Please list any other general operations, health problems, or major illnesses you have had

_____
_____
_____

Please read ALL policies listed below.

Financial Policy

If you have insurance, it is **your responsibility** to understand your insurance benefits, obtain your referral, prescription, or pre-authorization prior to your first visit. Integrative Therapeutics, Inc. is not responsible for checking on your coverage or requirements. **If we have not received your referral or authorization by your second visit, we will be unable to provide physical therapy services until your insurance company has authorized treatment. You will be responsible for payment of all services provided without authorization**. It is important to understand that having insurance does not guarantee payment for the services rendered. Therefore the account balance, subject to the terms of your insurance contract, is ultimately **your responsibility** as is any balance from lapse in coverage or rejection of payment. It is the policy of this office that all patients pay in full at the time of service for any copayment, deductable, coinsurance or the charges for the visit if paying privately.

Cancellation Policy

If a scheduled appointment with the therapist cannot be kept, kindly give us 24 hours notice. There is a $90 fee for appointments cancelled after that time. **Your insurance company is not responsible for paying this fee.**

Consent to Treat

I voluntarily authorize Integrative Therapeutics to perform outpatient diagnostic evaluation(s) and/or procedure(s) and to administer such outpatient therapy that is necessary or appropriate. I understand that outpatient therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

Authorization to Release Information

I authorize Integrative Therapeutics to obtain and/or release medical information regarding my treatment as is required to obtain payment for services. I also authorize Integrative Therapeutics to communicate with other health care providers, as is required to coordinate and provide treatment.

Assignment of Benefits

I hereby assign all benefits for services rendered that I am entitled to receive to be paid to Integrative Therapeutics.

Notice to clients with Tufts, Harvard Pilgrim, or Medical Claims Service, Inc. Insurance Coverage: It is the policy of Integrative Therapeutics that patients with these insurances pay for their physical therapy sessions in full at the time of service and seek reimbursement from their health insurance company themselves. Integrative Therapeutics will happily provide receipts and visit notes, and encourages clients to consult their insurance company for guidance with this process.

Acknowledgement of Receipt of Integrative Therapeutics, Inc.'s Notice of Information Practices

I have: (check one) ☐ Received a copy of Integrative Therapeutics' Notice of Information Practices

☐ Been offered and declined the Notice of Information Practices.

Please note that our Notice of Information Practices is also posted in our waiting area and on our website.

Acknowledgement of Terms

By signing below I attest that all information given is true and accurate to the best of my ability. I understand that intentionally providing misleading information is unlawful. I have read and understand all of the policies stated above. I acknowledge that I am ultimately responsible for charges incurred as a patient of Integrative Therapeutics.

I understand and agree to all the above stated policies _____

Print Name

Signature and Date: _____ ___ / ___/ 20__