IPT 1 Barney Road, Suite 120, Clifton Park, NY 12065 Phone 518-373-0735 Fax 518-373-7967

INTEGRATIVE PHYSICAL THERAPY: Where healing hands and skilled minds meet www.InspiredTherapy.com

IPT WELCOMES YOU!

We appreciate that you have chosen Integrative Physical Therapy (IPT) for our manually focused, one-on-one physical therapy rehabilitative care.

We *require* the following information prior to your initial evaluation:

- The physician prescription or referral for treatment.
- Your insurance ID card.
- The attached completed patient intake forms

Please arrive 10 minutes prior to your evaluation appointment so that we may promptly process your initial registration prior to the start of your scheduled appointment (if you are unable to print and complete the attached patient intake forms, please arrive 15 minutes prior to your appointment and we will provide the forms to you then for completion).

Your initial evaluation is estimated to be approximately one hour. Please try to wear or bring loose comfortable clothing for all your appointments.

To avoid our late cancellation/no show fee, please contact the office with 24 hours' notice if you are unable to keep your scheduled appointment.

We accept all credit cards, debit cards, and checks for co-payment or co-insurance responsibility and therapeutic accessories. We do not accept cash payments.

Of final note, due to the dedicated care our clinicians strive to provide for you, please ensure your follow-up appointments are continuously scheduled out a minimum of (3) weeks in advance to maintain consistent treatment critical to your recovery.

Our office staff is available to assist with scheduling or questions you may have at **518-373-0735.**

We look forward to meeting you soon!

Integrative Physical Therapy

1 Barney Rd, Ste. 120, Clifton Park, NY 12065

PATIENT INFORMATION Date: _____ DOB: _____ Age:_____

Patient name: _____ Marital Status: __S __M __D __W Sex: __M __F
Address:_____ City: _____ State:_____ Zip: _____
Home phone: _____ Work phone:_____ SS#:_____
Occupation: _____ Referring Physician: _____ Primary Physician: _____
Employer's name: _____ Address:_____
Spouse's name: _____ SS#: _____
In case of emergency, contact: _____

If patient is a minor, please fill in the following as well as the above.
Legal guardian: _____ DOB: _____ Relationship: _____
SS#: _____ Address:_____
Home phone: _____ Message phone:_____

Have you had chiropractic, physical therapy or speech therapy this year? _____ If so by whom?
_____

Are you still currently receiving chiropractic treatment? _____
Are you currently receiving Home Health Care? _____

INSURANCE INFORMATION
Primary Insurance: _____ Employer: _____
Subscriber ID: _____ Group #: _____ Co-pay amount: _____
Employee's name: _____ DOB: _____

Secondary Insurance: _____ Employer: _____
Subscriber ID: _____ Group #: _____ Co-pay amount: _____
Employee's name: _____ DOB: _____

Workman's Comp Carrier: _____ Date of injury: _____
Carrier Address:_____
Carrier case #: _____ WCB #:_____ Carrier phone: _____
Employer name: _____ Address:_____ Phone:_____

No Fault Carrier: _____ Accident Date: _____
No Fault Carrier Address:_____
Policy #: _____ Claim #: _____ Policy Holder: _____

I authorize release of any information necessary to process my insurance claim, assign payments directly to my provider, and acknowledge that I am financially responsible for any unpaid balance. I assign all medical/surgical benefits to Integrative Physical Therapy. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____
(Parent/guardian if patient is under 21)

Payment of Medicare Benefits: I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to Integrative Physical Therapy for services furnished me by that physician. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits or the benefits payable for related services.

Signature: _____ Date: _____

List names of family, friends, or others that we my discuss your PHI with (include those who have permission to call on billing questions)_____
_____

Office Use only: HIPAA Consent Form Signed? Y N Restrictions to PHI Disclosure signed? Y N (If yes attach copy)

Health History

CONFIDENTIAL

Patient Name:_____**Today's Date**:_____

***Height_____ ***Weight_____(Please fill out height/wt) **Occupation**: _____

Symptoms: Check symptoms you currently have or have had in the past year.

General
__ Chills
__ Depression
__ Dizziness
__ Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Loss of weight
__ Nervousness
__ Numbness
__ Sweats

Muscle/Joint/Bone
Pain, weak, numb in:
__ Arms __ Hips
__ Back __ Legs
__ Feet __ Neck
__ Hands __ Shoulders

Gastrointestinal
__ Poor appetite
__ Bloating
__ Bowel changes
__ Constipation
__ Diarrhea
__ Excessive hunger
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal Bleeding
__ Stomach Pain
__ Vomiting
__ Vomiting Blood

Cardiovascular
__ Chest Pain
__ High blood pressure

Eye, Ear, Nose, Throat
__ Bleeding gums
__ Blurred Vision
__ Crossed Eyes
__ Difficulty Swallowing
__ Double Vision
__ Earache
__ Ear discharge
__ Hay fever
__ Hoarseness
__ Loss of hearing
__ Nosebleeds
__ Persistent Cough
__ Ringing in ears
__ Vision – Flashes
__ Vision – Halos

Skin
__ Bruise easily
__ Hives

Men only
__ Breast Lump
__ Erection difficulties
__ Lump in testicles
__ Penis discharge
__ Sore on penis
__ Other

Women Only
__ Abnormal Pap Smear
__ Bleeding between periods
__ Breast Lump
__ Extreme Menstrual pain
__ Hot flashes
__ Nipple Discharge
__ Painful intercourse
__ Vaginal discharge
__ Other

Are you pregnant? Y N

Conditions: **Check conditions if you have EVER been diagnosed with any of the below conditions.**

__ Aids
__ ADHD
___Alcoholism
__ Anemia
__ Anorexia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding Disorder
__ Breast Lump
__ Bronchitis
__ Bulimia
__ Cancer
__ Chemical Dependency
__ Chicken Pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Goiter
__ Gonorrhea
__ Gout
__ Heart Problems
__ Hepatitis
__ Hernia
__ Herpes
__ High Cholesterol
__ HIV Positive
__ High Blood Pressure
__ Kidney Disease
__ Liver Disease
__ Measles
__ Migraine Headaches
__ Miscarriage
__ Mononucleosis
__ Multiple Sclerosis
__ Osteoporosis
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate Problem
__ Psychiatric Care
__ Rheumatoid Arthritis
__ Scarlet Fever
__ Stroke
__ Suicide Attempt
__ Thyroid Problems
__ Tuberculosis
__ Typhoid Fever
__ Ulcers
__ Vision/hearing difficulties

Medications: **List all medications you are currently taking.**

_____
_____
_____
_____
_____
_____

LIST ALLERGIES: _____

Hospitalizations

Please list any serious illnesses or injuries along with the date and outcome

Year	Hospital	Reason & Outcome
___	_____	_____
___	_____	_____

Please X any of the following whose care you are under:

- ☐ General Practitioner
- ☐ Osteopath
- ☐ Orthopedist
- ☐ Chiropractor
- ☐ Physical Therapist
- ☐ Speech Pathologist
- ☐ Chiropractor
- ☐ Neurologist
- ☐ Psychiatrist/Psychologist
- ☐ Other (Please Specify)

If you have seen any of the above during the past 3 months, please describe for what reasons (illness, medical condition, physical, etc.)

How much caffeinated coffee or caffeine-containing beverages do you drink per day? _____
How many packs of cigarettes do you smoke per day? _____

How many days per week do you drink alcohol? _____
How many alcoholic drinks per day? _____

Have you RECENTLY experienced any of the following:

- ☐ Excessive weight loss/Gain
- ☐ Fatigue
- ☐ Weakness
- ☐ Nausea/Vomiting
- ☐ Fever/Chills/ Sweats

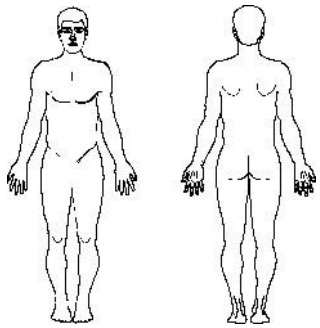
Describe Your Current Problem and How It Began:

_____

Onset date/Surgery date_____

Indicate below where you have pain or other symptoms

Is this? ❑ Work Related ❑ Auto Related ❑ N/A **How often are your symptoms present?**



❑Constantly (76-100% of the day) ❑ Occasionally (26-50% of the day)
❑Frequently (51-75% of the day) ❑ Intermittently (0-25% of the day)

Describe the nature of your pain:

❑Sharp ❑ Dull Ache ❑ Numb ❑ Shooting ❑ Burning ❑Tingling

How is your condition changing?

❑Getting Better ❑ Not Changing ❑ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ❑ Yes ❑ No

What areas were taken? _____

PLEASE LIST ALL RECENT SYMPTOMS /PROBLEMS RELATED TO WHY YOU ARE COMING FOR PT:

_____
_____
_____
_____
_____
_____

I certify that the above information is correct to the best of my knowledge. I will not IPT or any members of IPT's staff responsible for any errors that I may have made in the completion of this form.

Signature: _____ Date: _____

Integrative Physical Therapy

Patient Attendance Policy Agreement

Integrative Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule to your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize waiting times and assure continuity of your personal treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

Cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients**. We must ask for your full cooperation with the following policy:**

- If you are unable to keep a scheduled appointment, we request that you notify our office 24 hours in advance of your scheduled appointment time. If someone is not available to take your call, please leave a message on our answering system.

- All cancellations and no-shows will be documented in your medical records and appropriately communicated to your physician and Insurance/Third Party Payor.

- If you accumulate 2 cancellations or no-shows, your therapist may refer you back to your Physician before scheduling another appointment or may choose to discharge you from therapy and report this to your Physician.

- If you do not honor a scheduled appointment either by late cancellation (less than 24 hours of notice) or no show, then you will be charged **a $25.00 fee, due upon your next scheduled visit.** Note, after 2 cancellations, the fee will go up to $50.00.

IPT would like to thank you for your cooperation. As you may be aware, most PT clinics in the tri-district area treat 3-4 patients an hour. In an effort to see only 1-2 patients an hour **we have no choice but to charge this cancellation fee regardless of any circumstances.**

Patient Acknowledgment/Signature:

_____ Date: _____

Email Address:

Integrative Physical Therapy (IPT)
Notice of Privacy Practices

Effective Date: 14 April 03

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

IPT is required by law to maintain the privacy of your health information, to follow the terms of this notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this notice. We reserve the right to change our practices and this notice and to make the new notice effective for all medical information we maintain. Upon request, we will provide a revised notice to you.

How IPT May use or disclose your health information

1. Treatment: We may use your health information to provide, coordinate, or manage the healthcare and related services that are provided to you by healthcare practitioners, enable your healthcare providers to consult among themselves about your condition, and to refer you to a new healthcare provider.

2. Payment: We may use and disclose medical information about you in order to be paid for the services rendered to you. This may include contacting your health insurer to determine the existence of insurance coverage, sending copies or excerpts of your health information to your health insurer to receive payment, and using your health information for our own internal management of the billing process. By way of example, a bill sent to your insurance company may include information that identifies you and the procedures used to provide services to you.

3. Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.

4. Healthcare Operations: We may use and disclose your health information in connection with quality assessment and improvement activities, reviewing the competence or qualifications or healthcare professionals, evaluating practioner and provider performance. As part of our healthcare operations, it may also become necessary for us to use and disclose your health information in connection with the healthcare operations of another company that has a relationship with you, such as an HMO.

5. Business Associates: We may use and disclose certain medical information about you to our business associates. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, and third-party billing companies. We require the business associate to protect the confidentiality of your health information.

6. *Victims of abuse, neglect, or domestic violence*: We may disclose your health information to a government authority, such as a social service or protective service agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

7. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services, Office of Civil Rights, HIPAA, 200 Independence Ave, SW, Washington, DC 20201.

When IPT May Not Use or Disclose your Health Information

Except as described in this Notice of Privacy Practices, IPT will not use or disclose your health information without your written authorization. If you do authorize IPT to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the following uses and disclosures, we must follow your state law.

You have the following rights with respect to your health information

1. You have the right to request restrictions on certain uses and disclosures of your health information. To make such a request, you must complete the Restrictions of the Use of Patient Information form and the request will apply only to the location providing services. IPT is not required to agree to the restrictions that you requested.

2. You have the right to inspect and copy your health information as long as IPT maintains the health information. To inspect or copy your health information, you must complete a Request to Inspect Medical Records form and submit the request to the location that provided your services. We may charge you a fee for the costs of copying, mailing, or other supplies necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

3. You have the right to request that IPT amend your health information that is incorrect or incomplete. To request an amendment, you must complete a Request to Amend Medical Records to the location providing services. IPT is not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.

4. You have a right to receive an accounting of disclosures of your health information we have made after April 14, 2003 for most purposes other than treatment, payment, health care operations, information provided to you, and certain government functions. To request an accounting, you must complete a Request for Accounting of Disclosure. You must specify the time period but may not be longer than six years. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

5. You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of your health information, you must complete a Request for Alternative Communication to the location providing services and will be good for only the location providing services. Your request must state how or when you would like to be contacted. We will accommodate

If you would like to exercise one or more of these rights, contact the location that provided your services or submit a written request to IPT, 1 Barney Rd, Suite 120, Clifton Park, NY 12065.

Changes to this Notice of Privacy Practices

IPT reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, IPT is required by law to comply with this notice. The revised notice will be posted in the center and will be available upon request.

By signing below, I acknowledge that I have received IPT's Privacy Notice and agree with all guidelines.

_____ _____

Signature of Patient or Authorized Representative Date