Medical History

Are you pregnant? Y / N **If yes, due date: _____**
Do you have a pacemaker? Y / N **If yes, when was it placed: _____**
Do you have a history of cancer? Y / N **If yes, what type: _____**
Do you have a history of falls? Y / N **If yes, last fall: _____**

List any significant medical history, including diagnosed medical conditions or surgeries.

_____
_____
_____

Have you had any diagnostic studies (MRI, x-ray, etc.) for your current condition?

_____
_____

Is your injury due to an accident or is there litigation involved? Y / N
If yes, is there a Letter of Protection (LOP)? Y / N
Have you had Home Health PT in the last 30 days? Y / N **If yes, discharge date: _____**
Have you had previous PT visits this year? Y / N **If yes, how many: _____**

List any medications that you are currently taking.

Medication Name	Dose	Frequency

We understand that medical information about you is personal. We are committed to protecting your medical information and are required by law to keep identifying medical information private. This signature provides consent for the release of medical records to my health insurance company, primary and/or referring physician, and for insurance submissions.

Patient's Signature: _____ **Date: _____**

Clinic Policies

Billing Practices

- I assign Integrated Physical Therapy and its affiliate businesses insurance benefits.
- I understand I am financially responsible for all charges, whether paid by insurance or not. Charges include, but are not limited to, copays, co-insurance, or self-pay pricing. I understand the patient is ultimately responsible for all charges for services rendered.
- Payment is expected when services are rendered.
- If you are using in-network benefits or low deductible ($2,500 or less) out-of-network benefits, Integrated Physical Therapy and its affiliate businesses will file claims for you.
- If you are using high deductible (>$2,500) out-of-network benefits or self-pay, Integrated Physical Therapy and its affiliate businesses will NOT file claims for you, but can provide you with an itemized bill if you would like to submit your claims for reimbursement.

Medicare Beneficiaries

- The patient is responsible for any deductible remaining at the time of service, unless you have a secondary insurance that covers the deductible.
- Please be aware Medicare has a ‘soft cap’ or maximum allowance for services before review each calendar year. This cap affects the number of visits you have available.

Late Arrivals or Cancellations

- If you arrive late, you are subject to the full fee for the session. We do not prorate fees.
- **We require 24 hours notice for all cancellations.** For in-network patients, late cancellations are subject to a $50 fee. For out-of-network or self-pay patients, late cancellations are subject to **the FULL fee** for the session.
- If 2 consecutive appointments are missed, we reserve the right to cancel all remaining appointments.

Consent

- This signature provides consent for physical therapy treatment including manual therapy, exercise, modalities, and any other therapies recommended.
- Our facility participates with accredited Doctorate of Physical Therapy programs and we accept graduate students for clinical education experiences. You may request to only receive treatment from a licensed therapist.
- This signature provides consent to take and use photos and/or videos for educational and social media purposes.

Patient's Signature: _____ **Date:** _____

Credit Card Authorization

Authorization Details: I authorize Integrated Physical Therapy and its affiliate businesses to keep the below credit card on file. I understand that the credit card may be charged for any patient balances including, but not limited to, copays and late cancellation fees. You will be notified prior to any charges being processed.

Cardholder's Agreement: I understand that I am solely responsible for the charges to my credit card. I also understand that any changes to the credit card information must be promptly communicated to the clinic.

Cancellation of Authorization: I may cancel this authorization at any time by providing written notice to Integrated Physical Therapy. I understand that it may take up to 3 business days for the cancellation to take effect.

Security and Confidentiality: I understand that my credit card information will be kept confidential and secure. Integrated Physical Therapy and its affiliate businesses will not disclose this information to any third parties, except as required for payment processing.

Processing Fee: There is a 3% processing fee for all credit card payments. To avoid this fee, you can pay with cash, Venmo, Zelle, or check instead.

Patient Signature: By signing below, I acknowledge that I have read, understood, and agreed to the terms and conditions outlined in this Credit Card Authorization Form.

Cardholder Name: _____
Credit Card Number: _____

- Expiration Date: _____
- Security Code (CVV): _____
- Billing Address: _____
- City, State, ZIP: _____

Patient's Signature: _____ **Date:** _____