Integrated Therapy, LLC
222 Peachtree Road, N.E. Suite D-336 Atlanta, GA 30309-106
Phone: (404) 351-5307 Fax (404) 351-5308

WELCOME TO INTEGRATED THERAPY, LLC

Thank you for choosing Integrated Therapy, LLC. We specialize in Aquatic based physical therapy and are among the nation's largest provider. Our therapists work hard to create treatment plans tailored to the individual in order for you to achieve your goals.

Our goal is to provide you with the highest quality personalized care that you require. If you have any questions, or develop any concerns during your course of treatment here, we ask that you let us know immediately so we can address your concerns right away. Following your initial evaluation, subsequent appointments will be scheduled per your physician's order. Always advise your therapist of any changes in your pain or functional status before your treatment session starts each time.

If you are delayed or late for your appointment, please call your therapist directly. Please notify your therapist 24 hours before your appointment to cancel and reschedule. If your therapist cannot be reached, please notify the office by leaving a message with the office manager. Failure to notify your therapist or this office of a cancelled appointment may result in a $50 charge. You will be responsible for payment of this charge as insurance companies will not pay for missed appointments. We must notify Worker's Compensation insurance companies when patients have missed three scheduled appointments and benefits may be terminated.

We will verify your insurance coverage at the time your first appointment is scheduled. Physical Therapy benefits are different from physician office visits, therefore, co-pays may differ as well as a maximum cap on total charges. Co-Payments must be paid to the therapist at the time of each visit. You will be responsible for any amounts not paid by your insurance company. Overdue accounts will be billed interest at the rate of 18% per annum.

If Medicare is your primary insurance, we will bill your secondary insurance, if any, as a courtesy. Secondary insurance usually does not pay for charges not allowed by Medicare and upon denial we will bill you. If you are a Medicare patient, you must see your doctor for a re-evaluation 90 days after your initial evaluation. This must be done in order for you to continue with your physical therapy.

If you are seeking therapy due to an automobile accident, you will be responsible for the cost of your treatment unless you provide us with written authorization from an insurance company that they will be responsible for your treatment charges. We will be happy to bill the insurance company, however, you will be responsible for any amounts not paid by the insurance company.

We hope you enjoy your time with us and the benefit a therapy performed in the water. Please contact us if you have any questions regarding your course of treatments.

Patient/Responsible Party _____ Date _____

Integrated Therapy Representative _____ Date _____

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MEDICAL QUESTIONNAIRE

Name:	Phone:
Emergency Contact:	Phone:

Medications:
Allergies:

Referring Physician:

Do you have a fear of water?, if so explain: _____

Do you have allergies to Chlorine, Bromine or other chemical sensitivities? _____

Have you had a physical therapy in the past year? Y ( ) N ( )

Injury as result of a fall in the past year? Y ( ) N ( ) Have you had 2 or more falls in the past year? Y ( ) N ( )

Have you had surgery in the past year? Y ( ) N ( )

Explain: _____

Please check each item below if you have had experienced. If so, please explain answers briefly/describe other.

Allergies	Yes No	Dizzy Spells	Yes No	MRSA	Yes No
Anemia	Yes No	Emphysema/Bronchitis	Yes No	Multiple Sclerosis	Yes No
Anxiety	Yes No	Fibromyalgia	Yes No	Muscular Disease	Yes No
Arthritis	Yes No	Fractures	Yes No	Osteoporosis	Yes No
Asthma	Yes No	Gallbladder Problems	Yes No	Parkinsons	Yes No
Autoimmune Disorder	Yes No	Headaches	Yes No	Rheumatoid Arthritis	Yes No
Cancer	Yes No	Hearing Impairment	Yes No	Seizures	Yes No
Cardiac Conditions	Yes No	Hepatitis	Yes No	Smoking	Yes No
Cardiac Pacemaker	Yes No	High Cholesterol	Yes No	Speech Problems	Yes No
Chemical Dependency	Yes No	High/Low Blood Pressure	Yes No	Strokes	Yes No
Circulation Problems	Yes No	HIV/AIDS	Yes No	Thyroid Disease	Yes No
Currently Pregnant	Yes No	Incontinence	Yes No	Tuberculosis	Yes No
Depression	Yes No	Kidney Problems	Yes No	Vision Problems	Yes No
Diabetes	Yes No	Metal Implants	Yes No		
Head Injury	Yes No	Mental/Nervous Disorder	Yes No	Skin Conditions	Yes No
Hypoglycemia	Yes No	Open Wounds	Yes No	Other	Yes No

Explanation:

Patient signature _____ Date _____

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Consent for Treatment and Authorization

Your physician has referred you to Integrated Therapy, LLC. The following information will give you an understanding of our payment and insurance filing policies.

- Insurance: We will file your primary insurance for you if you provide us with the appropriate insurance information. You will receive a statement for the remaining balance after your insurance carrier has paid their portion. The office does not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Your are responsible for payment of any amount not paid by your insurance.
- Medicare: We will submit your Medicare claim and accept assignment. Since we are a specialty service, you are responsible for your Medicare deductible and the remainder of the charge. You will receive a statement each month until the account is paid out. You may use a copy of the bill, or the Medicare EOB you receive at the time of service, to file any additional insurance you may have. If you provide us with proper insurance information we will bill your secondary insurance. If you do not have secondary coverage you are responsible for the unpaid balance.
- Worker's Compensation: Please provide us with the proper information required to verify coverage. We will submit all charges to your workman's compensation carrier for payment. If worker's compensation does not pay for your treatment, you will be responsible for the bill.
- Legal Cases: We cannot treat on a contingency basis, therefore, where legal cases are pending settlement, we ask for payment at the time of service.
- Non-covered Treatment: You may request additional physical therapy sessions, which are not covered by your insurance policy. However, you will be responsible for the charges for the entire sessions.

If you have any questions, we will be glad to assist you at 404-351-5307.

Consent for Treatment & Authorization: I do hereby consent to treatment by Integrated Therapy, LLC. I authorize Integrated Therapy, LLC to obtain any information required for my treatment. I assign all insurance benefits to integrated Therapy, LLC and authorize my insurance carrier to pay directly to Integrated Therapy, LLC. I understand that I am financially responsible for services rendered.

Patient or Parent/Guardian Name: _____

Patient or Parent/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

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Patient Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by notifying our business office at 404-351-5307.

You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except when we have already made disclosures in reliance on your prior consent.

Responsible Party Name: _____

Signature: _____ Date: _____