INTEGRATED THERAPY

Integrated Therapy, LLC

2221 Peachtree Road, N.E. • Suite D-336 • Atlanta, GA 30309-1106
Phone: (404) 846-0899 • Fax (404) 846-0886

WELCOME TO INTEGRATED THERAPY, LLC

Thank you for choosing Integrated Therapy, LLC. We hope your time with us will be pleasant and productive.

Following your initial evaluation, subsequent appointments will be scheduled per your physician's order. 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, so that someone else can be scheduled in your place. If your therapist cannot be reached, please notify the office by leaving a message with the office manager, or on the voicemail. Failure to notify your therapist or this office of a cancelled appointment may result in a $50.00 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. We will advise you if benefits are different from physician office visits. 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.

If Medicare is your primary insurance, we will bill your secondary insurance, if any, as a courtesy. Medicare does not pay for equipment, supplies or braces. Secondary insurance usually does not pay for charges not allowed by Medicare. However, we will bill your secondary, and upon denial we will bill you. Medicare requires that you see your physician every 30 days while you are receiving physical therapy. If you do not see your physician, as required, they will not pay for your therapy.

If you are involved in 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.

Overdue accounts will be billed interest at the rate of 18% per annum.

We hope your visits with us will be healing and beneficial. 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

Patient Name _____ Phone _____ Facility _____
Have you had a physical exam in the past year? ____ Yes ____ No
If yes, when? _____ Physician _____ Phone _____

Have you had an x-ray in the past year? ____Yes ____ No
If yes, please indicate dates and what was x-rayed. (Example: 12/1/99, left foot)
_____

Please list all medications taken on a regular basis
_____

Please list all allergies _____

How is your general health? _____ Your endurance/strength _____ Do you have any fear of water? _____

Are you a swimmer? _____ Are you afraid of deep water? _____ Are you afraid in shallow water? _____

Do you have allergies to Chlorine, Bromine, or any chemical sensitivities? _____ Any skin rashes or allergies? _____

Please check yes or no for each question on your own health history.

Please explain all yes answers briefly on the back of this sheet.

Yes	No		Yes	No	
___	___	Open wounds	___	___	Stroke
___	___	Low/High blood pressure	___	___	Knee injury
___	___	Heart disease	___	___	Muscle weakness
___	___	Chest pain (angina)	___	___	Angioplasty
___	___	Hearing/vision problems	___	___	Swollen ankles
___	___	Rheumatic fever	___	___	Head injury
___	___	Asthma	___	___	Severe headaches
___	___	Hay fever	___	___	Mental/Nervous disorder
___	___	Vertigo	___	___	Nausea
___	___	Abnormal chest x-ray	___	___	Anemia
___	___	Neck pain	___	___	Hemophilia
___	___	Fainting / Dizziness	___	___	Sickle Cell anemia
___	___	Epilepsy/seizures	___	___	Kidney disease
___	___	Stomach ulcers	___	___	Venereal disease
___	___	Diabetes	___	___	Cancer
___	___	Hypoglycemia	___	___	Muscular dystrophy
___	___	Respiratory problems	___	___	Cerebral palsy
___	___	Thyroid problems	___	___	Multiple sclerosis
___	___	Ear infections	___	___	Parkinson's disease
___	___	Chronic illness	___	___	Surgery
___	___	Skin conditions	___	___	Prostate problems
___	___	Arthritis	___	___	HIV/AIDS
___	___	Gynecological problems	___	___	Hepatitis B
___	___	Back pain/injury	___	___	Alcohol (type/amt.)
___	___	Tobacco (type/amt.)	___	___	Hernia
___	___	Pacemaker	___	___	Contact lens wearer
___	___	Hearing aid wearer	___	___	Bowel incontinence
___	___	Bladder incontinence	___	___	Recreational drugs
___	___	Emphysema	___	___	High cholesterol

Patient signature _____ Date _____

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CONSENT FOR TREATMENT & 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 404-846-0899.

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.

Signed _____ Date _____
Patient or Parent/Guardian

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 404-846-0899. 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 Signature Date