INTEGRATED HEALTH, P.C.

421 PARK HILL DRIVE
FREDERICKSBURG, VA 22401

EMERGENCY INFORMATION (update annually or as changes occur)

Patient Name:		SSN:		Sex:
Date of Birth:	Phone: (home)	(work)	(cell)	
Physical Address *(please include city, state and zip code):*				
Mailing Address:				
Emergency Contact Name: Relationship (must be parent/guardian if patient is under 18): Home Phone: Work/Cell:				Marital Status:
Medical Doctor (PCP): Phone: Preferred Hospital in emergency:				
Employer name and address:				
Insurance Company(s): Policy/ID#: Subscriber Name: Subscriber DOB: Subscriber SSN: Subscriber Relationship to Patient:				
Workers' Compensation Company: Telephone: Contact: Claim #: Date of Original Injury:				
Medications:				
Allergies: YES___ NO____ (If yes, please specify. Include allergies to medication).				
Medical Problems/ concerns:				
Substance Abuse History:				

INTEGRATED HEALTH, P.C.

CONTRACT FOR SERVICES/BILLING AUTHORIZATION RELEASE OF INFORMATION

I, _____, hereby authorize Integrated Health, P.C. to render services to me (or my minor child). In addition, I authorize Integrated Health, P.C. to bill and accept payment from my insurance company(s) or workers' compensation company, _____, and to release information regarding medical history, diagnosis and treatment of my child or me to my insurance company regarding my claim. I understand that such information regarding me or my child shall be collected responsibly and maintained in a confidential clinical record. I understand that this information may be shared with a billing company for the purpose of collecting payment for services rendered.

I authorize Integrated Health, P.C. to exchange any and all information about my treatment with my primary care physician, _____, and/or my podiatric/orthopedic physician, _____ _____, by mail, e-mail, phone or fax for the purpose of coordinating care.

I hereby consent to any and all physical therapy treatment and evaluation procedures the licensed physical therapist considers necessary or advisable. I understand this may include, but is not limited to, orthopedic evaluation, modalities, dry needling, exercise or manual (hands-on) treatment.

I understand that I may be contacted by phone, mail or electronically and that messages may be left at my home, work, cellphone, answering machine or voice mail system, unless I request in writing that I am not to be contacted in one of the above referenced ways.

Medicare Patients: I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information for all Medicare claims. I assign the benefits payable for covered services to Integrated Health, P.C. and/or its practitioners.

I understand that my records are protected under federal and state confidentiality laws and regulations. Records cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I understand that I may revoke the consent at any time, except to the extent that action has been taken in reliance on it and that in any event this consent automatically expires as described below.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received or have been offered a copy of the notice of Privacy Practices for Integrated Health, P.C. Integrated Health, P.C. reserves the right to modify the privacy practices outlined in the notice.

_____ _____

Patient (parent/guardian) signature Date

_____ _____

Integrated Health staff signature Date

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM *this information has been disclosed to you protected by federal confidentiality rules (42 CFR, Part 2). Federal rules prohibit you from making any future disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

INTEGRATED HEALTH, P.C.

When you call to set up your initial appointment, we obtain your insurance information to help us get information from your insurance company involving your benefits. Our staff does this as a *courtesy* to all our patients. **Please be advised that the information we receive from your insurance company regarding authorizations/co-payments/deductibles can be incorrect or change. Integrated Health, P.C. will not be responsible for any incorrect/missing information received from the insurance company. It is ultimately your responsibility as the insured/guardian of patient to obtain all authorizations/referrals required by your insurance company and/or law.**

Medicare has an annual cap on physical therapy. This cap includes all physical therapy rendered at any clinic and/or at home. The staff at Integrated Health, P.C. can only keep track of services rendered at our facility alone. *It is your responsibility to keep track of any other physical therapy services you have outside of Integrated Health, P.C.*

I understand that I am financially responsible for any and all charges arising from treatment of the patient referenced (myself or my minor child). I understand Integrated Health, P.C. will bill my insurance company(s) as a service to me, but billing the insurance company is not a guarantee of payment. In the event that payment is not received from my insurance company, I agree to be financially responsible for any and all applicable charges and to pay them within 90 days of the date of service. I agree to satisfy my financial responsibilities with regards to co-payments, co-insurance, deductible and self-pay contract entered into with Integrated Health, P.C.

If you believe your care is or will be covered by Workman's Compensation or your insurance carrier changes, you must immediately notify us. You will be responsible for any charges not paid by the insurance company if we are not given appropriate notice of these changes.

Please double check your benefits with your insurance company. Integrated Health only checks the benefits of your primary insurance. If you have a secondary insurance, please check those benefits to ensure coverage.

Your insurance company states: You have a deductible of _____ of which you have met _____ . If you have no deductible, or after your deductible has been met your co-payment/co-insurance will be _____ per visit.

In signing, you understand that payments of co-payments, co-insurance, and/or deductibles is expected at the time of service.

_____ _____

Patient (parent/guardian) signature Date

_____ _____

Integrated Health staff signature Date

I understand that if I do not satisfy any or all financial responsibilities within 90 days of the date of service my account will be referred to a collection agency and/or attorney. In the event that this should happen, I, the undersigned, agree to pay 18% interest per annum on all balances which are unpaid 90 days past the date in which services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance, whether suit is filed or not; plus court costs.

INTEGRATED HEALTH, P.C.

LATE CANCELLATION/NO SHOW POLICY

Thank you for choosing Integrated Health, P.C. One of the best reasons to choose us is because we schedule generous amounts of time to care for you personally and to answer any questions or concerns you may have regarding your healthcare. We never double book or triple book our appointments and we strive for the best quality care for our patients.

To insure that all of our patients receive this benefit, please understand that we may reschedule or shorten your appointment if you arrive more than 10 minutes late.

For the same reason, **we require that you give us 24 hours notice if you are unable to keep your appointment.** Even if 24 hours notice is not possible due to unforeseen events, please call as soon as possible. This will allow us to either move forward with our day, or to offer your appointment time to another patient.

Should you fail to notify us 24 hours in advance that you are unable to keep your appointment, a fee will be added to your account. This fee is NOT reimbursable by your insurance. This fee is $50.00 per occurrence, and if you should fail to give us 24 hours notice a third time, our business office has the right to take you off the schedule indefinitely.

You will be responsible for paying this fee at your next scheduled visit, before you are seen. Please do not ask clinical or support staff to waive this fee. This is a company policy and is absolutely necessary for us to remain able to provide the high quality, one-on-one, individualized care our patients deserve.

_____ _____

Patient (parent/guardian) signature Date

_____ _____

Integrated Health staff signature Date

Confirmation Calls: As a service to our patients we offer a courtesy call two days before your next scheduled appointment to remind you of the time and date. Please be advised this is a courtesy only, ***failure to receive a courtesy call does NOT release you from attending your next appointment or giving appropriate notice for cancellations.*** Please remember there is a $50.00 fee per late cancellation/ no show occurrence.

In signing you agree that in the event we are unable to speak directly to you (the patient, parent or guardian) we may leave a message with whomever answers your telephone at home, work or cell phone and/or on your answering machine or voicemail system.

_____ _____

Patient (parent/guardian) signature Date

_____ _____

Integrated Health staff signature Date

PERMISSION FOR EMERGENCY CARE AND TRANSPORTATION

Integrated Health, P.C., or its representatives, have my permission in an emergency to take whatever measures necessary to insure my safety and life including, but not limited to:

1. Contacting my medical doctor (PCP).
2. Transporting me (or having me transported via rescue squad) to a hospital or other medical facility for the purpose of obtaining emergency treatment.
3. Obtaining emergency medical treatment for me as deemed necessary by the attending physician.
4. Contacting my emergency contact.

_____ _____

Patient (parent/guardian) signature Date

_____ _____

Integrated Health staff signature Date