Integrity Therapy Group, LLC
416 N. Seminary St. Ste. 100
Florence, Alabama 35630

Patient Name ______________________________ E-Mail: __________________________ Age: _____ Sex: _____

Address______________________________________ City_____________________ State_______ Zip___________

Phone____________________________________ D.O.B.______________ SSN________________ Marital Status _______
Home Cell

Occupation________________________ Employer___________________________ Wk. Phone__________________

Emergency Contact_____________________________ Phone___________________ Relationship ________________

GUARANTOR INFORMATION: (Insured Name)

Name____________________________________ Phone____________________ Relationship __________________

Address____________________________________ City_____________________ State________ Zip____________

D.O.B._________________ Guarantor SSN____________________ Occupation_______________________________

Employer____________________________ City & State __________________________ Wk. Phone _______________

Date of injury or accident: ______________________

INSURANCE INFORMATION:

Primary Insurance __________________________ Secondary Insurance __________________________
(Please provide us with a copy of your insurance cards)

Are you currently receiving, or have you received Home Health recently? __________If yes, give dates and Home Health Agency ______________NOTE: INSURANCE WILL NOT COVER OUTPATIENT PHYSICAL THERAPY IF CURRENTLY RECEIVING HOME HEALTH! PATIENT WILL BE RESPONSIBLE FOR ALL BILLS INCURRED. Have you received any out-patient physical therapy anywhere this year either with Integrity or other outpatient physical therapy services? ___________ If Yes, where ____

ADDITIONAL INFORMATION:

How did you hear about Integrity Therapy Group? (Check all that apply)

□ Employer □ Family / Friend □ Former Patient □ Physician □ Insurance Co. □ Magazine □ Newspaper □ Radio

□ Signage □ Yellow Pages □ Other ____

NO/SHOW CANCELLATION POLICY:

If a patient has 3 or more no-show's of scheduled appointment or cancellation's with less than a 24-hour notice of scheduled appointment, Integrity Therapy Group has the option of discharging patient due to non-compliance or contacting referring physician with intent to discharge due to non-compliance of orders. This policy has been put in action in order to respect other patient's appointments and timeliness of their treatment.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE NO/SHOW CANCELLATION POLICY:_________(initials)

Integrity Therapy Group is hereby authorized to provide physical therapy services to the above named patient for treatment. I authorize disclosure of all records to my insurance carrier. I hereby assign all medical benefits and payments provided to me by Integrity Therapy Group. In consideration of services rendered, I do hereby agree to guarantee payment of all services provided to me. Any charges not covered by insurance, will be billed separately and payment anticipated thereafter. Should it become necessary to send my account to a collection agency, I will be billed the cost of the collection services. In consideration for other patients receiving physical therapy, I will attempt at least a 24 hour notice if cancellation or rescheduling is necessary.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM:__________(initials)

Signature ____ **Date** ____________________

Guarantor Signature (Other than patient)___________________________________ **Relationship** _________________