ITG Patient Information Sheet

GENERAL INFORMATION

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 / POLICY HOLDER: (Insured Name- please fill out if insurance is not in your name)

Name ______________________ Phone ______________ Relationship ___________

Address ______________________ City ______________ State ________ Zip ________

D.O.B. ______________ Guarantor SSN ______________ Occupation ______________

Employer ______________ City & State ______________ Wk. Phone ______________

- **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 PT IF CURRENTLY RECEIVING HOME HEALTH! PATIENT WILL BE RESPONSIBLE FOR ALL BILLS INCURRED.***
- Have you received any out-patient physical therapy or rehab anywhere this year either with Integrity or other outpatient physical therapy/ rehab services? _____ If Yes, where ______________________

PLEASE READ

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-hr notice, 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 timelines of their treatment. **I HAVE READ AND FULLY UNDERSTAND THE ABOVE NO SHOW/ CANCELLATION POLICY**

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. **I HAVE READ AND UNDERSTAND THE ABOVE CONSENT**

Signature ______________________________________ **Date** ______________

DISCLOSURE OF HEALTH INFO

I acknowledge that I have received a copy of the "Notice of Privacy Practices" attached to the back of this packet. I understand that as part of my healthcare, Integrity Therapy Group, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, diagnosis, examinations, treatment and any plans for future care or treatment. I understand that this information serves as:

- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I wish to have the following restrictions to use or disclosure of my health information:

____

Please list any family members or friends that we can release your information to. Ex. Appointment times or billing information

____

I agree to the terms of this consent.

Signature ______________________________________ **Date** ______________

Guarantor Signature (Other than patient) ______________________ **Relationship** ______________