Patient Registration

INTEGRA PHYSICAL THERAPY

Patient Information			
Last Name:	Suffix:	First Name:	MI:
Address:		SSN:	
City:	State:	Zip:	
Mobile Phone:	Home Phone:	Work Phone:	
Email:	Sex M F	Date of Birth:	
Employer:	Student Status: Full Time / Part Time		

Insured Information (Leave blank if same as patient)			
Last Name:	Suffix:	First Name:	MI:
Address:		SSN:	
City:	State:	Zip:	
Mobile Phone:	Home Phone:	Work Phone:	
Email:	Sex M F	Date of Birth	
Employer:			

Emergency Contact Information		
Last Name:	First Name:	MI:
Relationship: Spouse Parent Friend Other:		
Mobile Phone:	Home Phone:	Work Phone:

Who is your referral source? i.e. physician, google, yelp, friends, insurance company, etc..

☐ Yes, I'd like to subscribe to Integra Monthly News Letters via email.
☐ Yes, Integra Physical Therapy can contact me regarding my appointments & account via email.

New Treatment Questionnaire

INTEGRA PHYSICAL THERAPY

Name:	Age:	Date:
Occupation:		
Chief complaint:		
How did injury occur:		
Date of onset:	Surgery date:	Reason for surgery:

Average pain intensity: last 24 hours: no pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

past week : no pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

Do you experience? □ Radiating Pain □ Numbness □ Tingling □ Sleep Disturbances

How often do you experience your symptoms? □ Constantly □ Frequently □ Occasionally □ Intermittently

How often have your symptoms interfered with your usual daily activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

In general, would you say your overall health right now is: □ Excellent □ Very good □ Good □ Fair □ Poor

Are you off work due to your injury/pain? □ YES □ NO since: ____/____/____

What activities/treatments improve your symptoms?

What activities/treatments worsen your symptoms?

List the medications you are currently taking: Please use back of the page for additional meds.

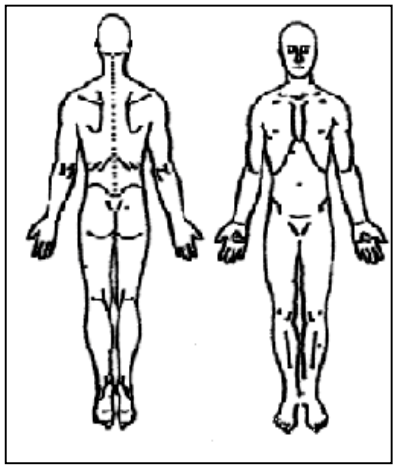
Medication Name	Delivery Method (oral, injection)	Strength	Frequency
ex: Levothroid (levothyroxine sodium)	ex: Oral	ex: .2mg	ex: once daily

List all healthcare providers you see for your chief complaint listed above:

List any diagnostic test (MRI/x-ray/CT scan) or injections for this condition:

Are you currently receiving any other care for this condition?

Circle where you have pain or other symptoms:



Are you now or in the past 30 days received home health care for **ANY** reason? □ YES □ NO
If so, with what company:

Have you received therapy in the past for this condition? If so, was it: □ YES □ NO
□ Successful □ Unsuccessful

Have you received therapy in this facility before? □ YES □ NO
If so, when and for what?

Do you have any current infections? □ YES □ NO

Do you have any open wounds? □ YES □ NO

Has your medical history changed since your last visit to this clinic? ☐ YES ☐ NO
If so, please explain:

Is this injury a result of an accident? ☐ n/a ☐ auto ☐ slip and fall ☐ work related ☐ other:

Medical History : Do you now or have you ever had any of the following? (Check all that apply)

_____ Diabetes	_____ Arthritis	_____ High Blood Pressure
_____ Heart Disease	_____ Heart Attack	_____ Pacemaker / Surgical Implant
_____ Hernia	_____ Headaches	_____ Kidney Problems
_____ Cancer / Tumor	_____ Seizures	_____ Metal in Body
_____ Previous Fractures	_____ Thyroid Problems	_____ CVA / Stroke
_____ Anxiety	_____ Osteoporosis	_____ Depression
_____ Deep Vein Thrombosis (DVT)	_____ Substance Abuse	_____ Hepatitis (☐ A, ☐ B, ☐ C)
_____ Hypersensitivity to Heat/Cold	_____ Asthma	_____ HIV / AIDS
_____ Other: _____		

Explanation & approximate date:

Do you smoke tobacco? ☐ YES ☐ NO

Are you or could you be pregnant? ☐ YES ☐ NO

Do you have allergies? ☐ YES ☐ NO
If so, please list:

Have you had any surgeries in the past? ☐ YES ☐ NO
If so, please explain:

Are you currently – please circle one of the following:

☐ Employed ☐ Unemployed ☐ Retired – Date:_____ ☐ Disabled – Date:_____

_____ _____
Patient / Guardian Signature Date

06/12

TMJ Questionnaire

INTEGRA PHYSICAL THERAPY

Have you ever had an injury to your jaw, face, or head even as a child? □ Yes □ No
If so, approximately when and what was the cause of injury?

Have you ever had orthodontic care/braces? □ Yes □ No **If so, approximately when?**

Have you had any recent oral surgeries, long dental procedures, or general surgery?

Have you recently experienced an increase in stress due to work, family, or personal issues?

Do you awaken with: □ sore teeth □ headaches
□ sore jaw muscles □ stiff neck □difficulty opening your mouth

Do your jaw joints: □ pop/click □ get "stuck" □ feel tired
□ lock closed □ lock open □ feel painful/sore □ make a gritty noise

Do you experience: □ ear ringing □ ear fullness □ ear pain □ dizziness
□ neck pain □ neck stiffness □ headaches □ hearing loss □ facial numbness

Do you engage in any of the following: □ grinding your teeth □ clenching your teeth
□ smoking □ nail biting □ playing an instrument □ gum chewing
□ singing □ chewing pens/pencils □ biting your lip/cheek/tongue □ frequent talking

If you grind or clench your teeth, when do you do so?
□ with stress □ when sleeping □ at work □ during the day □ when playing sports

Do you wear a night guard or daytime split? □ yes □ no □ over-the-counter □ custom

Has your bite changed since the onset of your symptoms?

Do you have restless sleep, awakening several times a night? How many times a night?

What is your sleeping position? □ back □ stomach □ r/l side □ combination

How many pillows do you use? **Do you use lumbar support when sitting?**

NOTICE OF PRIVACY PRACTICES

INTEGRA PHYSICAL THERAPY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/18/2012), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.20 for each page, $35 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Tony Hall

Telephone: 512-501-1888

Fax: 512-428-8189

E-mail: tony@integrapt.com

Address: 1202 FM 685 Ste C3, Pflugerville, TX 78660

Policy Notice

INTEGRA PHYSICAL THERAPY

Regarding Insurance & Payment Policy

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We must emphasize that as physical therapy providers, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. It is our policy to call and verify benefits and eligibility in order for us to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed, at which time there may a balance due on your account. In the event that this occurs we will mail you a statement and appreciate your prompt payment. We will accept the contracted rate & take the necessary adjustments if we are a participating provider with your insurance. Payment for service is due prior to or upon completion of each treatment visit. We accept cash, checks, MasterCard, Visa & American Express. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

Initial _____

Non-covered Expenses

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to an insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance company does not cover due to limitations of the policy or what they consider reasonable and necessary. It is your responsibility to know what the policy limits are. Our goal is to improve your condition successfully based on what the doctor and the physical therapist deem reasonable and necessary treatment, not on what your policy limits are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

Initial _____

Consent and Acknowledgement of Receipt of Privacy Notice (HIPAA)

I understand that as part of the provision of healthcare services, Integra Physical Therapy creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested. By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations, be restricted. I also understand that the practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Initial _____

Consent to Treat, Assignment of Benefits & Release of Information

The undersigned consents to be (have minor) treated by Integra PT on an outpatient basis, which includes services rendered under the general and specific instructions of patient's physician or surgeon. The undersigned hereby assigns to Integra PT all payments for services rendered to patient. The undersigned understands and accepts responsibility for any amount not covered by insurance, except in workers' compensation claims. I hereby authorize Integra PT to furnish any and all information concerning my (minor's) treatment or illnesses to my (minor's) insurance carriers, attorney or other health professionals. I further authorize any holder of medical or other information about me (minor) pertaining to my (minor's) treatment or diagnosis to release it to Integra PT.

Initial _____

Cancellation and No Show Fees

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Integra PT reserves the right to charge a fee of $25.00 for missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice. Fee will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. You will not be charged if you reschedule your appointment within the same day.

Initial _____

_____ _____ _____

Patient Signature (Parent or Guardian Signature if Minor) Date Printed Patient Name

_____ _____

Witness Signature Date

revised 06/13