PATIENT INFORMATION:

Patient Name (*print*): ____
Responsible Party (if a minor): __________________Relationship to patient: ____________
E-mail address____
*Emergency contact? ______________________________ Tel #: _____________________

Patient Birth Date: ___ /___ /____ Sex: F / M Age: ____
Social Security #: _____-____-_______

Home/Mailing Address: ____
City: __________________ State: ___________ Zip: __________

I authorize Integrative Physical Therapy to call and leave a message at the following numbers:
Home: __________________Cell: _______________Work: ____________________________

BILLING INFORMATION: Please indicate who we are billing for these services.

Insurance: (please bring or provide a copy of your plan card or authorization letter if applicable)
Primary insurance**:** ____
Secondary insurance**:** ____
Patient is: the insured. The dependent – Insured name:________________________________

Workman's Comp: Is this work related? Yes No
Car accident? Yes No
Accident/Injury date: ___-___-_____Claim #______________________
Adjuster/Attorney: ___________________________________Contact Info:__________________

Other (payment) or **comments**:____
____
____

I certify that the information provided above is truthful and accurate: X___________________________
Print:__________________________

CONSENT FOR TREATMENT AND PAYMENT:

I understand that treatments administered to me by the staff of Integrative Physical Therapy And Spine Treatment Center, Inc. (IPT), while having the purpose of decreasing pain and improving function, may cause side effects including, but not limited to: soreness, stiffness, and fatigue, or other unforeseen outcomes. I further understand that failure to comply with treatment recommendations or instructions given to me by the IPT staff relating to my treatment or follow-up care may affect my treatment outcome. Although every effort will be made to maximize my progress while a patient at IPT, I do understand that it is impossible to predict or control the outcome in every treatment situation. I authorize this treatment and understand there is no guarantee of results.

____

Signature of Responsible Party (legal guardian if other than patient) Date

____

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize Integrative Physical Therapy And Spine Treatment Center, Inc. (IPT), to release any medical records required/requested by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to IPT. I agree that a reproduced copy of this authorization will be valid as the original. Per your insurance, this is not a guarantee of payment; all claims are subject to review according to your plans previsions. We will do our best, however***, it is not our responsibility to monitor your plans dollar or visit maximums.*** This is your (the patient's) responsibility. We encourage you to verify your own benefits as well. I understand that I will be responsible for any amount not covered by insurance or third party payer (such as Medicaid, Medicare or other Insurance Company) and that the balance is due upon receipt. All accounts that have not been paid in full within 120 days will be turned over to a collection company, Cornerstone Credit Services, LLC. We have a $35.00 returned check fee for all returned checks. IPT will not be held responsible for any non-covered or over the usual and customary expenses that is determined by the Insurance Company. ***Any remaining balance is ultimately the patients' responsibility***. I understand and accept these conditions and terms.

____

Authorized Signature of Subscriber/Patient Date

____

Office Policy

If at any time, you have questions or concerns with the quality of care you are receiving, please feel free to discuss your concerns with our administrator. As experienced specialists we will continually strive to provide you with individualized attention as well as attempt to satisfy your expectations and maximize your progress. Please be aware that we will accommodate your schedule on a "first come first serve basis". We do ask that patients not currently working be flexible in scheduling in the appointments during the mid-morning and mid afternoon. This allows working patient's access to morning, lunch and late afternoon appointments and minimizes their loss of work time. We understand that at times an illness or emergency may cause you to miss or cancel an appointment. However, because there are a large number of patients waiting to utilize our therapy services, missed appointments are unfair to these patients and are also detrimental to your care. If you are late for an appointment, we will make every attempt to complete your entire treatment; however, this may not be possible if there is a patient scheduled immediately after you. If you are more than 10 minutes late, we may need to reschedule your appointment. If you're here as scheduled and we do not initiate your treatment on time, you will receive full treatment. Repeated cancellations and/or failure to comply with treatment will result in discontinuation of care.

____

Signature of Patient Date

Notice of Privacy Practices for Patients (HIPAA)

This notice explains how medical information about you may be used and disclosed. It also details how you can get access to this information. Please review it carefully and then sign at the bottom as acknowledgement of receipt of this notice. You may be provided with a copy of this notice if requested.

- In a constantly changing healthcare environment, our practice is committed to educating our patients about healthcare issues that affect them. As a result, we have provided below general information about the Health Insurance Portability and Accountability Act of 1966 (HIPAA) for your review. Our practice is complying with HIPAA's regulations and would be happy to answer any questions you might have.

- Integrative Physical Therapy and Spine Treatment Center, Inc. is required by law to be compliant with the Privacy Rule by April 14, 2003.

- Protected health information (PHI) means any personal health information as defined by law, including demographic information that is collected from a patient by a healthcare provider or other entity that could potentially indentify the individual. PHI includes all medical records and other individually identifiable health information held or disclosed regardless of how it is communicated (e.g. electronically, written, or verbally).

- TPO refers to the treatment, payment or healthcare operation of Integrative Physical Therapy and Spine Treatment Center, Inc.

- In other words, our practices can use or disclose PHI for performing any activity that it deems necessary for: 1)providing quality patient care, 2) ensuring that our practice gets paid for services, 3) operating our practice. Some examples of these activities are use of PHI by the physical therapist and clinical staff to treat a patient, use of PHI by the business office staff to verify insurance information for billing purpose, use of PHI to obtain a referral, and use the PHI for our practice's business planning and internal management activities.

  I understand the Integrative Physical Therapy and Spine Treatment Center, Inc. may share my health information for treatment, billing, and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand the organized healthcare arrangement has the right to change this notice at any time. I may obtain a current copy by contacting Integrative Physical Therapy and Spine Treatment Center, Inc.

  My signature below constitutes my acknowledgement that I have been provided with this information above, and that a copy of the notice of privacy practices is available to me upon my request.

____ ____________________

Signature of Patient or Legal Representative Date

INTEGRATIVE

PHYSICAL THERAPY AND SPINE TREATMENT CENTER, INC

Past Medical History Survey

Patient Name: ____ Date: ___/___/___

Referring Physician:_______________________________________

Date of Birth: ___/___/___ Last MD Appointment: ___/___ /___ Next MD Appointment: ___/___ /___

The following is very important in our evaluation process. Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

Do you have any history of the following?

"

"	Yes	No
High blood pressure		
Circulatory problems		
Heart trouble		
Pacemaker		
Epilepsy		
Diabetes		
Pregnancy		
Blackouts		
Visual disturbances		
Headaches		
Weight change (more than 15 lbs)		
Respiratory ailment		
Ringing in ears		
Bowel or bladder		
Malignancy		
Stroke		
Aneurysm		
Pelvic		
Tail bone injuries		

Please advise of any know allergies: ______________

____

If you checked yes to any of the above, is your Dr. addressing these issues Yes _____ No _____

____

MEDICATIONS: Please list any medications that you are currently taking.

____

____

____

THE

*Quick*DASH

OUTCOME MEASURE

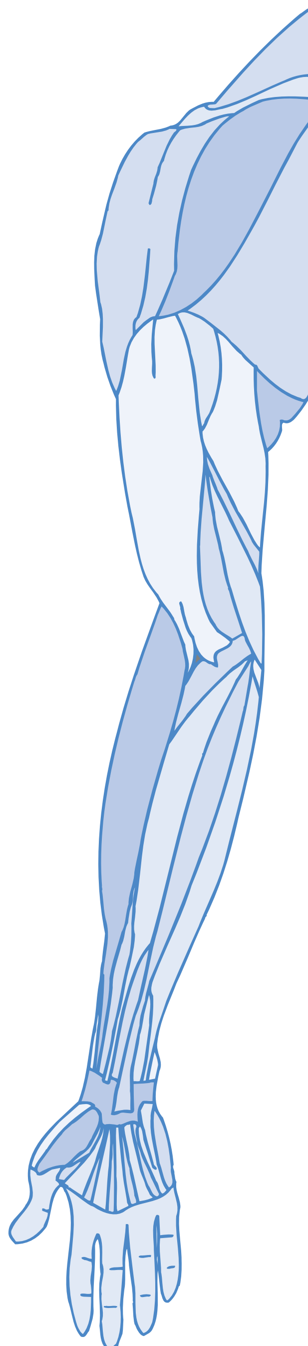
INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.



*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

***Quick*DASH DISABILITY/SYMPTOM SCORE** = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may not be calculated if there is greater than 1 missing item.

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:______________________________

❐ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:______________________________

❏ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.

An optional module score may not be calculated if there are any missing items.

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