NEW PATIENT INFORMATION RECORD (PLEASE PRINT LEGIBLY)

Patient Name | **Marital Status** S M D W Sep | **Date of Birth** | **Age** | **Social Security #**

Street Address | **City** | **State** | **Zip** | **Home & Cell # (Please put a * by Preferred #)**

Patient's Employer | **Occupation** | **Yrs Employed** | **Business #**

Employer's Street Address | **City** | **State** | **Zip**

Name of Emergency Contact | **Relationship to Patient** | **Phone #**

Spouses' Name/Responsible Parent if Minor

Spouses Employer/Responsible Parent if Minor | **Occupation** | **Yrs Employed** | **Business #**

Referring Physician | **Phone & Fax #** | **Date of Onset/Injury**

Is Your Visit the Result of (circle one): **Auto Accident (MVA)** **Employment** **Other Accident** **Other**
Please Explain Condition/Reason for PT:

INSURANCE INFORMATION

Skip this Section if Paying for Services

Subscriber Name | **Subscriber's Date of Birth** | **Relationship to Subscriber**

Insurance Company Name and Circle One: **Personal Ins.** **L&I** **MVA** **ID#** **Group#**

Insurance Company Address | **City** | **State** | **Zip** | **Phone#**

Does Your Insurance Require a Doctors Prescription/Referral for Physical Therapy (circle one)? **Yes** **No**

Agent/Case Manager Name | **Agent/Case Manager's Phone #** | **Claim/Case #**

If MVA, Do You Have PIP Coverage (circle one)? **Yes** **No** **If Yes, Which Company pays the PIP?**

Attorney Name(if applicable | **Attorney Address** | **Phone#/Email**

AUTHORIZATION: THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND BILLING MY INSURANCE IS A COURTESY PROVIDED TO ME FROM INTEGRATIVE PHYSICAL THERAPY AT NO ADDITIONAL COST, AND DOES NOT RELIEVE MY FINANCIAL RESPONSIBILITY. I UNDERSTAND THAT INTEGRATIVE PHYSICAL THERAPY CONTRACTS BILLING SERVICES WITH AT HOME! SERVICES/SHELLY DOMENOWSKE. I AGREE THAT INTEGRATIVE PHYSICAL THERAPY AND/OR AT HOME! SERVICES/SHELLY DOMENOWSKE MAY FURNISH THE RESPONSIBLE INSURANCE COMPANY, AND OTHER AUTHORIZED PARTIES, WITH NECESSARY INFORMATION TO PROCESS PHYSICAL THERAPY CLAIMS ON MY BEHALF IN A TIMELY MANNER. I UNDERSTAND I AM RESPONSIBILE FOR ALL DEDUCTIBLES, COPAYMENTS, AND SERVICES NOT COVERED BY MY INSURANCE CARRIER.

LAST MINUTE CANCELLATIONS OR NO SHOWS ARE NOT PAYABLE BY INSURANCE AND ARE A $25 CHARGE THE FIRST TIME THEN FULL PRICE OF THE USUAL VISIT.

Office Use Only
Diagnosis Code: _____
_____

_____
RESPONSIBLE PARTY SIGNATURE DATE

Revised 5-9-16

Integrative Physical Therapy
Emily C. Lou, PT, CHP

Personal Health Information (Confidential)

Name: _____ DOB: _____ Occupation: _____

Referred By: _____ Diagnosis:_____

Are you currently under the care of a physician or other health care practitioner?
If yes, explain: _____
Are you currently seeing a psychotherapist or are you attending regular support group meetings?
If yes, explain: _____

CURRENTLY, WHAT IS YOUR PRIMARY CONCERN? _____

_____

History of this primary concern: _____

_____

_____

Test/Results so far: _____

_____

_____

Treatment/Results so far, including medications: _____

_____

What specific results do you want/expect in your body and life? _____

_____

_____

PAST MEDICAL HISTORY: _____

_____

History of Illness: _____

_____

Any surgeries and when: _____

Accidents/Injuries/Pain: _____

_____

_____

Other: _____

_____

Previous treatment tried: _____

_____

_____

Have you had previous bodywork and what type? _____

_____

List exercise and stress reduction activities and indicate how often: _____

_____

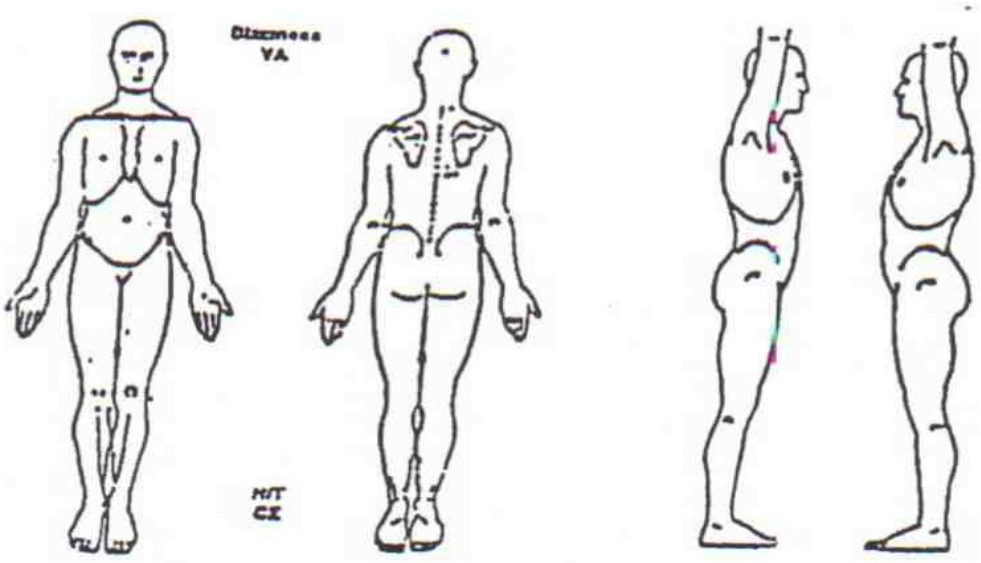
List any medications you are taking? Please include Aspirin, Ibuprofen, vitamins, etc: _____

(Optional)
The following questions are designed to enable both you and your practitioner to monitor the results of your case.

Please rate each item on scale of 0-10, 10 being the highest, most positive.

	Before	After	Comments
Physical Appearance	____	____	_____
Health	____	____	_____
Presentation	____	____	_____
Well Being	____	____	_____
Energy Level	____	____	_____
Sexual Enjoyment	____	____	_____
Freedom from Tension	____	____	_____
Knowledge of Body	____	____	_____
Ability to Deal w/Stress	____	____	_____
Self Esteem	____	____	_____
Freedom from Pain	____	____	_____
Expressing Emotions	____	____	_____

Indicate symptomatic area of your body by drawing on the figures below. Please comment as needed.



Signature: _____ Date: _____

INTEGRATIVE PHYSICAL THERAPY
PRIVACY POLICY

Integrative Physical Therapy is committed to maintain the confidentiality of your medical and financial information, which is referred as your "personal information". This policy informs you bout how we collect, use and disclose your personal information and your rights regarding that information.

OUR RESPONSIBILIES TO PROTECT YOUR PERSONAL INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Integrative Physical Therapy must take appropriate measures to protect the privacy of your personal information. Examples of your personal information include your name, social security number, address, telephone number, employment, medical history health records, claims information, etc.

We protect your personal information in numerous ways. For example, we authorize access to your personal information by our employees and business associates only to the extent necessary to conduct our business of serving you. We take steps to secure our office and electronic systems from unauthorized access. Our employees are trained in our privacy policies and procedures. Our privacy policy and practices apply equally to personal information about current or former patients.

We are required by law to:

- **Protect the privacy of your personal information;**
- **Provide this notice explaining our duties and privacy practices regarding your personal information; and abide by the terms of this policy.**

HOW WE MAY COLLECT AND DISCLOSE YOUR PERSONAL INFORMATION

We collect most of your information directly from you. By your submittance of the personal information sheet when you become our patient/client, we may also obtain your personal information from third parties without your specific authorization. These third parties may include health care providers, other health plans or insurers, and state and federal agencies.

We may use or disclose your personal information without your specific authorization for the purposes described below.
Treatment, Payment, Individuals involved in your care or payment for your care, As required by law, Legal proceeding, Law enforcement, and Military/National security.

For other purposes, we will request you specific authorization in writing, which you may grant or reject. If granted, you can revoke the authorization at any time by letting us know in writing.

YOUR RIGHTS REGARDING PERSONAL INFORMATION

You have the following rights regarding the personal information we maintain about your.
Your right to:
Inspection, Amendment, Restriction request, and Confidential Communications.

CONSENT AND DISCLOSE

Patient (name) _____ does hereby consent to the use and disclosure of healthcare information regarding patient for the purpose of the healthcare operations of Integrative Physical Therapy. Patient has the right to review Integrative Physical Therapy's privacy notice, to request restrictions on Integrative Physical Therapy's use and disclosures of the health care information and to revoke this consent to release information.

Dated: _____

Patient Signature: _____

(Parent or Guardian if pt. is under the age of 18)

Printed name of Patient: _____

(Parent or Guardian if pt. is under the age of 18)

INTEGRATIVE PHYSICAL THERAPY

CONSENT FOR TREATMENT

I hereby apply for and consent to treatment, at Integrative Physical Therapy. The general process and various results of treatment have been explained to me to my satisfaction. I understand that these results vary from individual to individual and that no specific results can be guaranteed.

Furthermore, I understand that any relief of physical or emotional symptoms is coincident with alignment and organization of the total human being, and that this is not the primary goal of treatment.

I understand that the Practitioner does not prescribe for or diagnose any illness, disease, or any other physical or mental disorder, injury or condition. Nothing said or done by the Practitioner should be construed to be such. I further understand that the Practitioner is not attempting to practice medicine, chiropractic, psychology or any other profession not qualified for requiring a license under the laws of the State of Washington.

I understand that it is necessary for the Practitioner to touch my body in order to assist me in establishing balance and alignment in my body. I give the Practitioner full privilege and license to work on my body in such a way as to restore and establish balance and alignment therein. I understand if I am not comfortable with anything, it is my responsibility to make it known, so a change can be made.

I understand that photographs and video tape recording may be made as visual/auditory aid for both Practitioner and myself.

I agree to provide complete and accurate information related to my case. I agree to pay for any appointments that I miss or do not cancel at least 24 hours in advance.

Signature Date

Thank you for taking the time to read this over and sign. Your cooperation supports and enhances the work of therapy. I look forward to working with you.

Emily C Lou, PT

4/13/2018