

NEW PATIENT INFORMATION RECORD (PLEASE PRINT LEGIBLY)

<u>Patient Name</u>	<u>Marital Status</u> S M D W Sep	<u>Date of Birth</u>	<u>Age</u>	<u>Social Security #</u>
<u>Street Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Home & Cell # (Please put a * by Preferred #)</u>
<u>Patient's Employer</u>	<u>Occupation</u>	<u>Yrs Employed</u>	<u>Business #</u>	
<u>Employer's Street Address</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	
<u>Name of Emergency Contact</u>	<u>Relationship to Patient</u>	<u>Phone #</u>		
<u>Spouses' Name/Responsible Parent if Minor</u>				
<u>Spouses Employer/Responsible Parent if Minor</u>	<u>Occupation</u>	<u>Yrs Employed</u>	<u>Business #</u>	
<u>Referring Physician</u>	<u>Phone & Fax #</u>	<u>Date of Onset/Injury</u>		
<u>Is Your Visit the Result of (circle one):</u> <i>Please Explain Condition/Reason for PT:</i>	Auto Accident (MVA)	Employment	Other Accident	Other

Integrative Physical Therapy uses text message reminders to alert you of upcoming appointments.

Would you like us to send you text message reminders ? (YES or NO)

If YES, please provide a cell phone number at which we can reach you:

Same as above or _____

AUTHORIZATION: THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE COMPANY IF I WISH TO KNOW IF SERVICES ARE REIMBERSIBLE AND HOW TO GO ABOUT SUBMITTING A CLAIM.

I UNDERSTAND 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 THEREAFTER.

RESPONSIBLE PARTY SIGNATURE

DATE

Office Use Only

Diagnosis Code: _____

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: _____

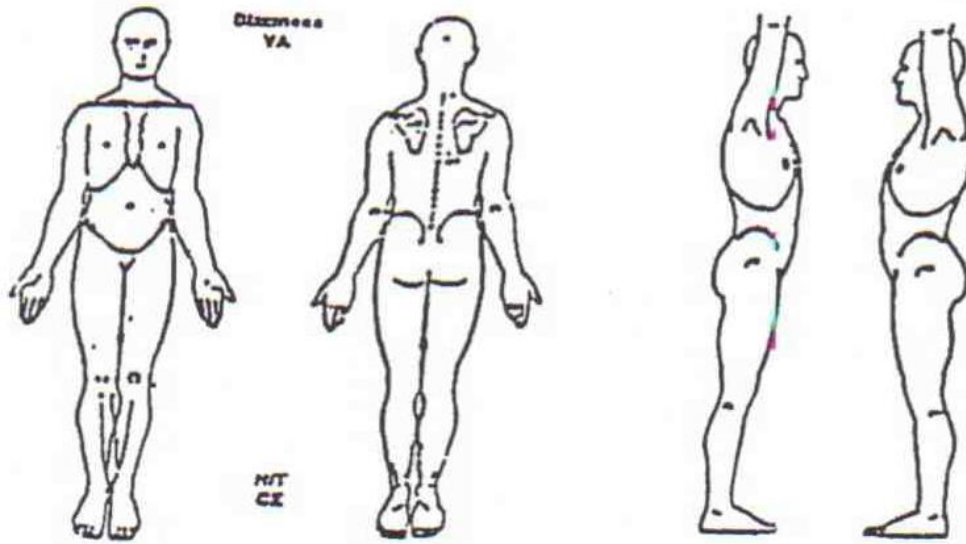
(Optional)

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 about how we collect, use and disclose your personal information and your rights regarding that information.

OUR RESPONSIBILITIES 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 your 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 you.

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

7/18/2018

