Beyond
INTEGRATIVE PT

Patient Information

Name _____DOB _____Age_____

Address: _____

Phone Number _____ Email Address_____

Occupation/Sport_____

Spouse/Guardian_____

Name Phone Number

Emergency Contact_____

Name Phone Number

Primary Physician_____

Name Phone Number

Attorney Info (if applicable) _____

How did you hear about us?

_____

_____

Patient/Guardian Signature: _____

Printed Name: _____ Date: _____

Financial Agreement

_____ **(Initial)** Beyond Integrative Physical Therapy is not contracted with any PPO insurance carriers. I understand physical therapy services are provided on an out of network basis. Beyond Integrative Physical Therapy cannot guarantee my insurance company will reimburse in part or whole the services provided. I agree to pay up front, all fees and charges related to treatment (deductibles, copays, coinsurance, or the entire balance).

_____**(Initial) Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and many of the visceral manipulation and craniosacral therapy services are not always considered covered services. Since we are not enrolled providers, we cannot submit claims to Medicare *and* Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. By choosing to receive our services, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

_____ **(Initial) Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.

Consent to Treat

_____ **(Initial)** I consent to have Beyond Integrative Physical Therapy to provide physical therapy services at Beyond Integrative Physical Therapy's Office, in my home or office. I hereby agree to participate in and consent to receive the physical therapy interventions recommended by my PT as outlined in my treatment plan. I understand that the response to different physical therapy interventions varies from person to person and sometimes treatment interventions may result in increased pain, an aggravation of existing symptoms or a new injury. Therefore, I agree to inform my PT of any change in my symptoms and function so my treatment plan can be adjusted accordingly. I understand that I may decline any intervention at any time by informing my PT of my desires/concerns and that my refusal may result in a termination of my treatment if my PT determines that there are no other treatment alternatives or the refused intervention is essential to meeting my goals. I also understand that although we have set rehabilitation goals, my PT has made no guarantees that any particular outcomes will result from the therapy interventions.

I have read this consent form, understand the benefits and risks involved in physical therapy, and agree to fully cooperate and participate in the proposed physical therapy interventions in the established plan of care. I understand that this consent may be changed, adjusted or revoked by me at any time.

Patients Name (printed) _____

Patient's Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you consent to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email or texting communication.
- ☐ I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail
- ☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent to)
  - ☐ Email
  - ☐ Text
  - ☐ Voicemail

E-mail address: _____

Phone number: _____

Patient Signature: _____Date: _____

Cancellation / No Show Policy

_____ (**Initial**) When I schedule a one-hour in office or in-home physical therapy appointment with Beyond Integrative PT that time is reserved for me. When you do not provide a minimum of 24-hour notice of cancellation, this does not give your physical therapist the opportunity to offer your time to another patient in need of treatment. If I cancel an "in office" or “in home” appointment *less than 24 hours* or *no show* to an "in office" appointment, I agree to allow Beyond Integrative PT to charge me. The cancellation fee is equal to the normal cost of the “in office” or “in home” treatment.

Payment for Services

_____ (**Initial)** Beyond Integrative PT accepts cash, check, Debit, Credit, HSA/FHA, ACH and Zelle as payment options for rendered services. I understand if I choose to use the credit card payment option. The credit card processing fees of ~3% will be added to the total as a surcharge convenience fee.

By signing below, I hereby authorize Beyond Integrative PT to charge my credit card, for the agreed amount for services rendered as well as the ~3% surcharge. Debit or HSA/FHA cards will be charged for the agreed amount for services rendered, only. I understand that this information is to be kept private and secure by Beyond Integrative PT.

Credit Card Type: VISA/MC/AMEX **Zip Code:** _____**CSV Code**: _____

Account Number: _____ **Exp. Date**: _____

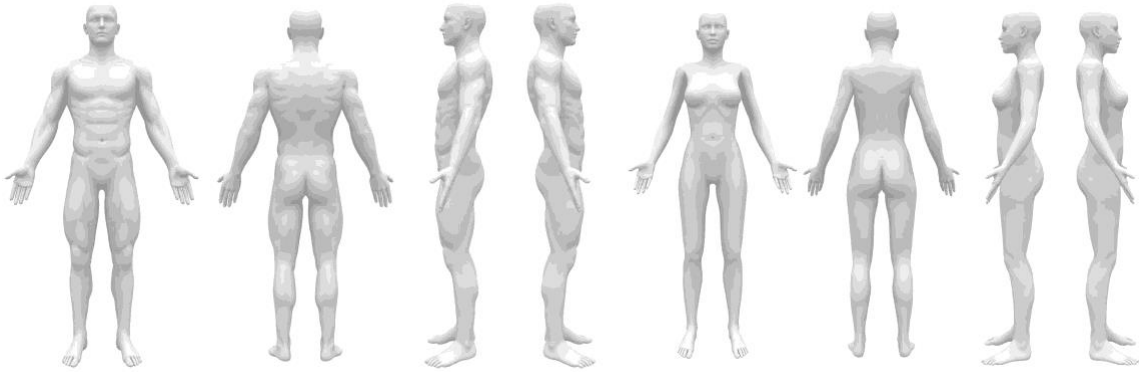
Cardholder Name:_____

Signature of Authorized Card Holder: _____

Health Questionnaire

This health questionnaire will help in the whole-body evaluation process. An understanding of your medical history will aid in a thorough understanding of your health and its relation to your musculoskeletal system.

After printing this document, please mark with an (X) on the body chart where you experience your current symptoms. Please indicate on a scale of 0-10, 0 being no pain and 10 being the worst pain your symptoms are currently.



Please *circle* which of the following symptoms describe your current condition.

Ache	Sharp	Dull	Numb	Burning	Tingling
Catching	Popping	Clicking	Shooting	Stiff	Loss of Balance
Throbbing	Weak	Swollen	Heavy	Constant	Intermittent

Do you have difficulty with the following activities due to your current condition?

	(Circle Yes or No)	
1. Sitting	Yes	No
2. Standing	Yes	No
3. Sleeping	Yes	No
4. Walking	Yes	No
5. Stairs	Yes	No
6. Reaching	Yes	No
7. Carrying	Yes	No
8. Lifting (___lbs)	Yes	No
9. Push/Pull	Yes	No
10. Dressing	Yes	No
11. Stairs	Yes	No

Circle Yes or No if you currently experience any of the following:

1. Fever/Chills	Yes	No
2. Fatigue	Yes	No
3. Nausea/Vomiting	Yes	No
4. Headaches	Yes	No
5. Dizziness/lightheadedness	Yes	No
6. Fainting/loss of consciousness	Yes	No
7. Double vision	Yes	No
8. Ringing in the ears	Yes	No
9. Difficulty swallowing	Yes	No
10. High blood pressure	Yes	No
11. Low blood pressure	Yes	No
12. Chest pain	Yes	No
13. Shortness of breath	Yes	No
14. Asthma/wheezing	Yes	No
15. Diabetes	Yes	No
16. Abdominal cramping	Yes	No
17. Ulcers	Yes	No
18. Heartburn	Yes	No
19. Bloating	Yes	No
20. Constipation	Yes	No
21. Diarrhea	Yes	No
22. Indigestion/GERD	Yes	No
23. Loss of appetite	Yes	No
24. Feeling of fullness	Yes	No
25. Difficulty eating fatty/greasy foods	Yes	No
26. Pain with urinating/bowel movement	Yes	No
27. Urinary frequency	Yes	No
28. Urinary tract infection	Yes	No
29. Sinus congestion	Yes	No
30. PMS	Yes	No
31. Cramping during menstruation	Yes	No
32. Skin rash/eczema/skin conditions	Yes	No
33. Stroke	Yes	No
34. Seizures	Yes	No
35. Sleep disturbed by pain	Yes	No
36. Sudden weight loss	Yes	No
37. Fever/Chills	Yes	No
38. Inner thigh/groin numbness	Yes	No
39. Recent infection	Yes	No

Are you under the care/supervision of an MD or DO for any current/related condition(s)?

Have you had any previous treatment for the current condition you are seeking treatment for? _____

Do you have a history of surgeries?

Please describe your current level of function.

Please list current medications, supplements, vitamins, minerals, etc.

Do you have a history of falling, tripping, stumbling?

Do you have any environmental, food, or medication allergies?

Do you smoke?

Please list any additional pertinent information that may be related to your current condition.