**Integrity Physical Therapy Services**
3095 N Genesee Rd, Flint, MI 48506
Phone: (810) 715-9988
Fax: (810) 715-9981

## CONSENT OF TREATMENT FORM

I, _____, give permission for Integrity Physical Therapy Services to provide me with medical treatment.

1. I allow Integrity Physical Therapy Services to file for insurance benefits to pay for the care I receive.
    a. I understand that:
        i. Integrity Physical Therapy Services will have to send my medical record information to my insurance company.
        ii. I MUST pay my share of the costs for services provided.
        iii. I MUST pay the cost of these services IF my insurance does not pay or I do not have insurance coverage.
2. I understand:
    a. I have the right to refuse any procedure or treatment
    b. I have the right to discuss all medical treatments with my clinician

Signature: _____ Date: _____

Parent Signature (patient under 18): _____

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OFFICE POLICIES

MISSED APPOINTMENTS:

There is no charge to any patient who cancels an appointment with 24 hours notice. However, to have a scheduled appointment with time allotted for your care and not keep that appointment results in clinician time that could be used to treat other patients. Therefore, canceling your appointment with less than a 24 hour notice, could result in a charge of $25.00. If you do not give any notification that you are not coming and do not keep your appointment, you will be charged a $50.00 no show fee.

HMO PATIENTS:

It is the patient's responsibility to be sure the written authorization from the primary care physician instructing the insurance carrier to pay their claims is received prior to their appointments. We attempt to assist our patients in all areas to obtain these referrals, however, the patient must be sure it has been received if they wish their insurance to pay their claims. Any questions regarding HMO referrals should be directed to our medical biller, Infinite Revenue Medical Billing, LLC.

**I have read and understood these policies.**

Signature: _____ Date: _____

Parent Signature (patient under 18): _____

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## PATIENT NOTIFICATION REGARDING DEDUCTIBLES AND COPAYS

This letter is intended to help patients understand insurance costs. Insurance can be confusing and/or overwhelming at times. It is always our intention to be as helpful as possible so that no one gets unexpected charges or bills. However, there are thousands of different insurance plans and contracts, therefore it is impossible for our staff to know the details of each and every policy. **It is your responsibility** to know your particular insurance cover and what procedures it covers. You should be aware of your deductible, if you have met it, and what your copays or coinsurance are after you have met it. We do our best to help you with this, and in preparation for your appointment, we verify eligibility and what amount is remaining to meet your deductible. Per insurance guidelines – office visit co-pays, deductibles and non-covered services must be paid in full **at the time of service.**

Please remember that a deductible is not the same as a copay and it MUST be met first, before your copay applies. For example, if you have a $1,000.00 deductible and a $20.00 co-pay, and our office visit cost is $150.00, you could pay $150.00 NOT just your $20.00 co-pay. You will continue to pay full cost of any procedures until you have paid $1,000.00. Then, each time you are seen you will pay only your $20.00 co-pay. This applies to all of your medical care, not just at our practice. This is an example and your particular plan may differ.

If you have a high deductible insurance plan, we are happy to speak with you before any procedures to help you estimate what types of cost you will incur. Please keep in mind, your insurance policy is a contract between you and your insurance company, and not with the doctor. We are here and happy to answer any questions you may have.

**Deductible:** Amount must be paid by you before insurance begins to pay your providers.

**Co-pay:** A set amount that is paid by you after you have met your deductible amount.

**Co-insurance:** A percentage of what is owed by the patient for a service.

**Out of pocket maximum:** A total amount of deductible and co-pays that you are responsible for in your yearly contract.

I have received, read, and understood this information.

Signature: _____ Date: _____

Parent Signature (patient under 18): _____

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## ELECTRONIC TRANSMISSION

As a patient of Integrity Physical Therapy Services, I give permission to use electronic transmission (e.g. communicate to other doctors via the internet) to carry out my treatment if necessary. Office of Integrity Physical Therapy Services may contact you through electronic transmission if needed, or refer you for further treatment through electronic transmission.

Signature: _____ Date: _____

## FINANCIAL AGREEMENT

All payments are due at the time of service. This includes deductibles, co-pays, co-insurance and any balances. We accept Visa, Mastercard, Discover, American Express, checks, cash and Care Credit.

**Medicare Authorization:**

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Finance Administration, and its agents, any information needed to determine these benefits for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature will authorize releasing the information to the insurer or agency shown. In Medicare assigned cases Integrity Physical Therapy Services agrees to accept the charge determination of the Medicare carrier as the full charge, and I (the patient) am responsible for the deductible, coinsurance, or non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

**Insurance Authorization:**

I request that payment of authorized benefits be made on my behalf to Integrity Physical Therapy Services for any services furnished to me. I understand that my signature requests that payment may be made and authorizes the release of medical information necessary to pay the claim.

***I understand that I am liable to pay for any referrals, co-pays, deductibles, and non-covered services imposed by my insurance company and accept the above statements. I further understand and agree that should it by necessary to institute collection remedies for non-payment, that I will be responsible for the principal balance due on my account, plus a collection fee of 33.3%.***

Patient Signature: _____ Date: _____

Parent Signature (patient under 18): _____

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## HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

**May we confirm appointments by:**

o Phone: _____

o Email: _____

o Text: _____

o Other: _____

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**May we leave a message on your:**

- o Answering machine at home: YES NO
- o Cell phone: YES NO

**May we discuss your medical condition with any members of your family?** YES NO
If YES, please name the family members below:

_____

_____

_____

Patient Printed Name:_____

**Signature:**_____ Date:_____

Parent Signature (patient under 18): _____

## How did you hear about us?

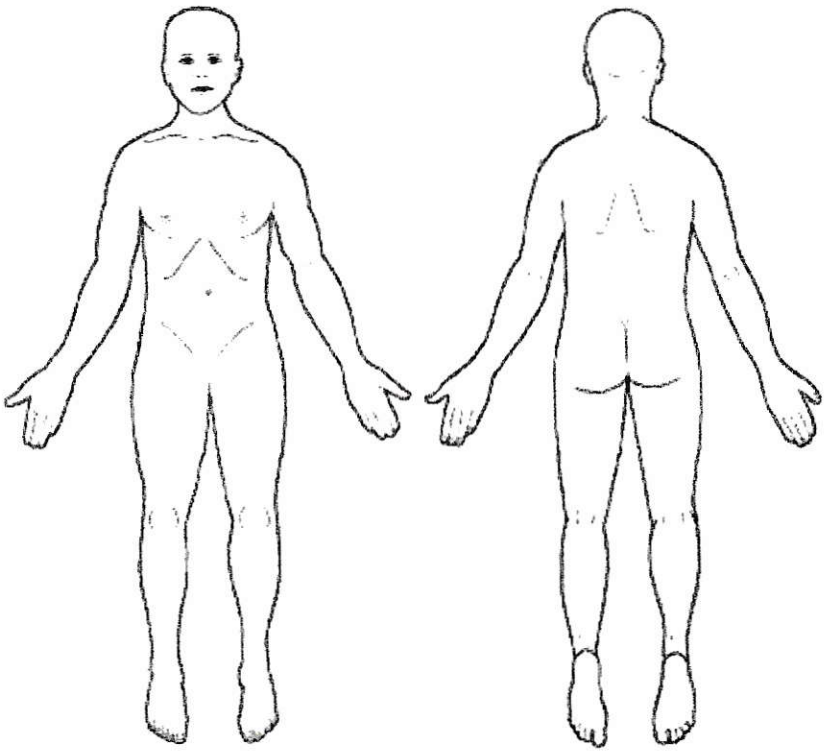
- o Facebook
- o Yelp
- o Google Search / Website
- o Dr. Referral: Dr. _____
- o Friend/Family Referral: Name _____
- o Passing by / Live near us
- o Other: _____

# Pain Scale and Body Diagram

Patient Name: _____

Today's Date: _____

**Please mark the location of your symptoms on the body diagram below.**



Mark on the scale **how strong** the pain is (1=slight pain, 10=extreme pain), *specifying the number of the body part subjected to pain.*

**When resting** 0 ——————————————— 10

**When mobile** 0 ——————————————— 10