INTEGRATIVE PHYSICAL THERAPY, LLC

37 Soundview Rd, Suite 2
Guilford, CT 06437

Today's Date_____ New Patient_____ Returning Patient_____

Patient Information:

Name_____ Date of Birth_____
Address_____ Home Phone_____
_____ Work Phone_____
Employer/School_____ Social Security No._____
Emergency Contact _____ Emergency Phone_____
How did you hear about us?_____
Was your diagnosis related to an accident? Yes__ No __ If yes, date of accident _____
E-mail address- _____

Guarantor Information:

Name_____ Date of Birth_____
Address_____ Relationship to Patient_____
_____ Employer_____
Insurance Company_____ Phone No._____
Insurance ID No._____ Insurance Group No._____

BUSINESS OFFICE INFORMATION

_____ **Assignment of Insurance Benefits**

Initials I authorize that the payment of my insurance benefits be made directly to Integrative Physical Therapy, LLC. For all services delivered; if I am paid directly I will promptly pay Integrative Physical Therapy, LLC all monies paid to me

_____ **Guarantee of Payment**

Initials I understand that all payments designed as 'the patient's responsibility' such as co-pays, co-insurances, and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date. I understand that I will be financially responsible if my insurance company does not pay for services rendered.

_____**Certification of Information**

Initials I certify that the information I have provided Integrative Physical Therapy for payment is accurate and truthful

_____**I understand that I will be charged a cancellation fee if I do not cancel my appointment**

Initials **within 24 hours**

CONFIDENTIALITY

*Your medical records are protected under Connecticut state law and Federal law (HIPAA). We require your written consent to release any protected health insurance information on your behalf.

*I authorize Integrative Physical Therapy, LLC to release information necessary to process insurance claims on my behalf. I also acknowledge that I have received the Notice of Privacy Practices.

Patient Signature_____ Date_____

Parent or Guardian if under 18_____