PATIENT INFORMATION:

First Name_____ Last Name_____

Preferred name_____ DOB_____/_____/_____

Home address_____

Home Phone_(_____)_____ Cell phone_(_____)_____

Email address_____

Social Security Number (of responsible party) _____-_____-_____

Employer_____

Employer's Address_____

Emergency contact:

Name_____

Relation_____

Phone_(_____)_____

Gender: (Circle one) Male Female Trans Prefer not to say

Referring physician_____

Have you had any other physical therapy this year? Y N If yes, when _____

Appointment reminders: (Circle one) Text message Email Decline

INSURANCE INFO:

Is this a Worker's Comp case? Y N Currently in litigation for your injury? Y N

Relationship to insured (circle one) Self Spouse Child Dependent Other_____

Primary insurance company _____

Policy number_____ Group number_____

Secondary insurance company (If applicable) _____

Policy number _____ Group number_____

If patient is a minor:

Mother's name _____Phone number_____

Father's name _____ Phone number _____

Legal guardian's name _____ Phone number_____

MEDICAL INFORMATION:

Date of onset of symptoms _____

Date of surgery _____

Briefly describe what brings you to PT today _____

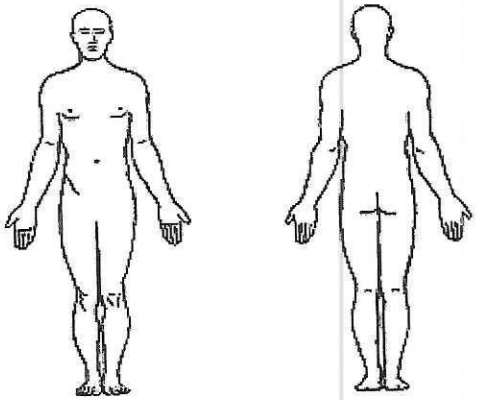
_____

Allergies (please list if applicable)_____ Latex allergy? Y N

Prior Surgeries_____

Currently pregnant? Y N

Pain/ Symptom location (please circle):



Please rate your pain: 0-10

Currently_____

At best _____

At worst_____

Medical conditions: (please check all that apply)

- ☐ Numbness/ tingling
- ☐ Radiating pain
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteopenia/ Osteoporosis
- ☐ Dizziness
- ☐ Nausea/ Vomiting
- ☐ Tripping/ Falls
- ☐ Gastrointestinal issues
- ☐ Weight loss
- ☐ Gout
- ☐ Cancer
- ☐ Change in bowel/ bladder function
- ☐ Headaches
- ☐ Seizures
- ☐ Chest pain
- ☐ Heart issues
- ☐ Pacemaker
- ☐ Other implanted devices
- ☐ other (please explain): _____

Occupation:_____

Recent imaging (within past year):_____

Current medications (names and dosages):_____

_____

I hereby certify that this medical information is accurate to the best of my knowledge

_____ _____

(Signature) (Date)

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for choosing INTEGRATION Therapy for your care. When you schedule an appointment with INTEGRATION Therapy, we reserve that time to provide you with the highest quality of care. If you need to cancel or reschedule an appointment, please contact our office by phone as soon as possible and no later than 24 hours prior to your scheduled appointment. This allows us to offer the time you cannot use to someone else who is waiting for care and can benefit from being seen.

Please review the Appointment Cancellation/No Show Policy below carefully:

- Effective 09/20/2021 any established patient who fails to show up for or cancels/reschedules an appointment without providing **at least 24 hours notice** will be considered a 'No Show' and provided **one courtesy reminder that a subsequent no show or late cancel will result in a $30.00 fee.**

- Any established patient who fails to show up for or cancels/reschedules an appointment without providing 24 hours notice a second time will be charged the $30.00 fee, which must be paid in full prior to the next visit.

- If a third No Show or late cancel/reschedule with less than 24 hours notice occurs, the patient may become ineligible for future visits with INTEGRATION Therapy.

- The fee is charged to the patient, not the insurance company, and is due no later than the time of the next office visit.

- As a courtesy, we are happy to provide printouts of scheduled appointments. If you do not receive or retain such a visit summary, you are still responsible for keeping track of your scheduled visits and the above Cancellation/No Show Policy remains in full effect.

INTEGRATION Therapy: 505-780-8783 Schedule changes must be made by calling the front desk. If it is after regular business hours Monday - Friday, a holiday or weekend, please leave a message. We understand that on rare occasions an unforeseen emergency may occur. If you should experience such an emergency, please contact our Office Manager to discuss the relevant circumstances.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms. I understand that violations of this policy may adversely impact my ability to be seen.

Printed Name _____

Relationship to Patient _____

Signature (Patient or Legal Guardian)_____

Date_____

CONSENT TO TREAT

I, _____ understand that I have been referred for rehabilitative treatment and care to Integration Therapy of Santa Fe. Integration Therapy will perform an Initial Evaluation and describe for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Integration Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payment policies and billing procedures of Integration Therapy of Santa Fe. I hereby authorize Integration Therapy of Santa Fe to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I herby assign Integration Therapy of Santa Fe all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to Outpatient Rehabilitation. It is understood than any money received from the above-named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Integration Therapy of Santa Fe for charges not covered by my insurance company. To include copays, deductibles and any other charge as it pertains to physical therapy. I certify by my signature that I have read and agree to this information.

Print Name: _____

Signature: _____ Date: _____