

# INTEGRATIVE PHYSICAL THERAPY, LLC

2351 Boston Post RD, Unit 204

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 \_\_\_\_\_

## 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 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 \_\_\_\_\_