PATIENT AGREEMENT

I certify that the information provided herein is true and correct. I do not hold Integrated Physical Therapy and/or its affiliates responsible for any incorrect or omitted information, or for any changes in my future coverage. I also agree that I am responsible for the contract between myself and the insurance company.

INSURANCE/PAYMENT AGREEMENT

I authorize the release of any information necessary to process claims. I request payment of benefits to Integrated Physical Therapy of Colorado. I understand and agree that I am responsible for any changes in my future insurance coverage. I also agree that I am responsible for the contract between the insurance company, and myself and am responsible for payment if my insurance company does not pay. I also acknowledge that Integrated Physical Therapy of Colorado has verified my insurance benefits, they have been explained to me and I have signed and received a copy for my records. I agree to let Integrated Physical Therapy of Colorado know of any changes in my insurance prior to my visit. Any outstanding account balance is expected to be paid in full prior to services being rendered. I agree to pay any outstanding balance owed to Integrated Physical Therapy of Colorado within 60 days after completion of my last therapy session. Should it become necessary for Integrated Physical Therapy of Colorado to utilize the services of an outside collection agency, I may be held liable for collection agency fees and/or attorney fees. We accept Cash, Check, Visa and MasterCard for your convenience.

Initials_____

CANCELLATION & NO SHOW POLICY

You are coming to therapy to remedy the condition that is affecting you; therefore it is absolutely necessary that you attend all of your scheduled appointments.

I acknowledge that any missed appointments interrupt the continuity of my care and may lead to slower recovery. Integrated Physical Therapy requires 48-hour advance notice for any cancellation. If you are unable to give 48-hour advance notice or you do not show for your scheduled appointment, an administrative fee of $40 will be charged to you. (not billable to your insurance company)

I have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

Initials_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of Integrated Physical Therapy's Notice of Privacy Practices (HIPAA). A copy of this notice is available upon my request. I further authorize the release of any personal health information required for treatment, payment, or health care operation. I have the right to revoke authorization for further uses at any time.

Initials_____

INTEGRATED PHYSICAL THERAPY OF COLORADO

CONSENT TO TREAT

I understand that I have been referred for rehabilitation treatment and care to Integrated Physical Therapy of Colorado. 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 was prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Integrated Physical Therapy of Colorado provide treatment and care.

Initials_____

PATIENT COMMUNICATION

By initialing below I agree that I am able to communicate with my Physical Therapist at Integrated Physical Therapy of Colorado via email, although it is not encrypted and as a result I accept the inherent risks.

Initials_____

By signing this form, I agree to all policies listed on this page.

Name: _____

Signature: _____ Date: _____