NEW PATIENT REGISTRATION

Integrative Physical Therapy

Name:		Date of Birth:	
Home Address:			
City, State, Zip:			
E-mail:		Home Phone:	
Cell Phone:		Work Phone:	

Where do you prefer to receive calls?	☐ Home ☐ Cell ☐ Work
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed
What is your current gender identity?	☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer ☐ Other _____ ☐ Prefer not to say
What is your gender for your insurance plan? *(Check one)*	☐ Male ☐ Female
What pronouns do you prefer that we use when talking about you? *(check all that apply)*	☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: Please specify: _____
How were you referred?	☐ Doctor ☐ Patient ☐ Other _____

Referring physician's name, address or telephone number:
Primary Care Physician's name, address or telephone number:
In the event of an emergency, whom should we contact?

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

☐ I agree to these terms.

PRIMARY INSURANCE COMPANY INFORMATION

Primary Insurance Co: _____

ID #: _____ Group #: _____

Policy holder (if other than patient): _____ Date of birth (if other than patient):

ASSIGNMENT OF BENEFITS/ AUTHORIZATION OF RELEASE MEDICAL INFORMATION/ CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO INTEGRATIVE PHYSICAL THERAPY, LLC, IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. ANY BALANCE UNPAID AFTER 120 DAYS IS SUBJECT TO A MONTHLY FINANCE CHARGE OF 18%.VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT ACCORDING TO THE ACTUAL BENEFITS QUOTED. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TOSECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF INTEGRATIVE PHYSICAL THERAPY, LLC, INC. AS MAY BY DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

☐ I agree to these terms.

SUBMIT PRINT

If you would like to Print a copy, do it before pressing Submit.
When you submit, your form will be transmitted to Integrative Physical Therapy. If you get a popup, click "Allow" to give permission for the submission to proceed. After the transmission, this PDF will automatically close.