Integrative Rehab and Wellness, Inc.
Patient Contact Information

Patient Name_____ Today's Date_____
Address_____City_____
State_____ Zip Code_____ DOB_____
Gender_____ Marital Status_____
Occupation_____ Home Phone _____
Work_____Cell _____
Other_____ Fax_____
Email_____

Parent/Guardian name if patient is a minor_____
Address (if different than patient)_____
DOB_____Relationship to patient_____

Emergency Information
Name_____ Relationship_____
Address_____ City_____ State___
Zip Code_____ Home Phone_____ Work _____
Cell Phone_____

********Would you like to receive confirmation of your appointments? Y N
If so, do you prefer email, text, or phone confirmation? _____

I/We authorize *Integrative Rehab and Wellness, Inc.* to release all medical information and/or records to my requesting insurance company and/or referring physician.

_____ _____
Signature of Patient/Guardian Date

Integrative Rehab and Wellness, Inc.

Patient Questionnaire

(This information is kept confidential)

Name_____ Today's Date_____
Gender_____ Age_____ DOB _____
Physician_____
How did you hear about us?
_____
History of current condition
_____
_____

What are your treatment goals? (reduce pain, increase mobility, etc.)_____
_____
Any special tests that have been performed, the body part tested, and the results: (ie: X-ray, MRI,CT Scan)_____
_____
_____
Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture) Please list practitioners.
_____
_____
_____
What has had a positive effect? _____
_____
What has had a negative effect? _____
_____
Have you been advised to have any surgery that has not been done?
_____
Please list all previous injuries, accidents, and any other pertinent medical information
_____
_____
_____
_____
Please list *all* medical conditions and/or health concerns
_____
_____

Please list *all* current medications:
_____
_____
_____
Please list all allergies:
_____
_____
Any previous surgeries? (please note year)

What activities do you enjoy that your current condition prevents you from doing?_____
_____
_____
List current fitness activities that you do regularly_____
_____
_____
Do you have known food or environmental allergies or sensitivities?_____
_____

Do you now have or have you had any of these symptoms in the past year? (check all that apply)

Change in bowel movements_____ Persistent joint pain_____
Irritable bowel_____ Blood in bowel/urine_____ Hot flashes_____
Vertigo or dizziness_____ Persistent nose bleeds_____
Difficulty concentrating_____ Learning disabilities_____
Tiredness/fatigue_____ Muscle spasms_____
Fainting spells_____ Eating disorder/difficulty_____ Difficulty Sleeping _____
Other_____

Any history of: (check all that apply)

Head or spinal injuries_____ Recurrent headaches_____ Meningitis_____
Stomach ulcers_____ Heartburn/indigestion_____ Shortness of breath _____
Anemia _____ Asthma _____
Bladder infection _____ Heart Problems _____
Depression _____ Other_____
Dental History: (please elaborate when possible)
Who is your dentist?_____
Ever wear braces? _____ Ever wear a retainer? _____
Grind or Clench your teeth? _____
Ever wear dental splint? _____ Currently using a night guard? _____ History of TMJ disorder? _____
Popping or clicking in jaw? _____ Jaw ever lock up? _____
Other: _____
Have you ever been knocked unconscious?_____ concussions?_____
Head/spinal injuries? _____

FOR WOMEN ONLY:

Please list number of: _____ pregnancies _____children
Any other information about pregnancies, complications with delivery, menstrual problems?
_____
_____

Integrative Rehab and Wellness, Inc.
OFFICE POLICIES & PROCEDURES

Welcome and thank you for choosing Integrative Rehab and Wellness, Inc. for your healthcare needs.

Patients are seen at Integrative Rehab and Wellness, Inc. by appointment only.

Please make every effort to arrive on time, however if you realize you will be late please contact us as soon as possible.

As a courtesy to us and to other patients trying to get scheduled, **we require a 24-hour (or greater) notice for cancellations**. This allows others on waiting lists to be seen. Only emergencies or illnesses are excusable. **A $50 fee will be billed upon violation of this policy.**

PAYMENT/BILLING POLICIES

Integrative Rehab and Wellness, Inc. is a fee-for-service clinic. This means that payment is due at the time services are rendered and we will NOT bill your insurance company. We can, upon request, provide receipts with diagnosis and treatment codes which you may choose submit to your insurance company. If further reports or documentation are requested, these will be provided. We accept cash, personal checks, and credit cards.

Medicare will NOT pay for services rendered at Integrative Rehab and Wellness, Inc. as we are *NOT* a Participating Provider with Medicare or any other insurance company, and we only agree to work with Medicare clients for fitness, prevention, and wellness goals (which are not covered services under Medicare). You will not be able to submit for reimbursement as our services do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually possess. Signing below means that you have received and understand this notice. You may receive a copy upon request at any time.

Given you will be paying at the time of services, if your insurance company reimburses our clinic, these monies will be returned to them and a new check must be cut to you personally. We are available for after hours, weekend, and home visits at additional costs. Supplies and additional items are also at additional costs. Please clarify prior to your first treatment if you have any questions regarding charges or fees.

PRIVACY POLICY

I understand that Integrative Rehab and Wellness, Inc. will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

CONSENT TO TREATMENT

Integrative Rehab and Wellness, Inc. is a hands-on Physical Therapy clinic. Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern, however, please ask if you have any concerns or questions. The number of treatments needed and recovery time can vary due to the age of injury, number of times injured, age of patient and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at Integrative Rehab and Wellness, Inc. I authorize Jessica Hartmann, PT to use treatment techniques as deemed necessary for my safe and effective recovery.

I have read and completely understand the above written statements.
X_____Date_____
Signature of patient/legal guardian

I also understand that Medicare will not reimburse for services rendered by Integrative Rehab and Wellness, Inc.
X_____Date_____
Signature of patient