Integrative Therapies

7E Oak Branch Drive Greensboro, NC 27407
www.integrativetherapies.net
336-294-0910

Hello! Welcome to Integrative Therapies and Integrative Pain Medicine,

We are very happy that you have chosen to partner with the Integrative healthcare team to support your wellness goals.

Accompanying this letter, there are a number of intake forms. We are aware that this may seem like a lot of material to review and respond to, however, please understand that our goal is to be thorough and to provide the best care that we can.

In order for our team to devise a personalized plan of care, it is helpful for us to know a lot about your medical history and your current healthcare needs. Thank you very much for your time and attention to these documents and for bringing your completed forms with you to your first appointment. Completing the forms prior to your appointment is very important and will allow you much more quality time with your evaluating clinician.

Most of the time spent in the initial visit will involve an exchange of information. To highlight some of the important things, we will provide you with a packet of information that you can refer to whenever you need to. The packet can also be used as a place to put any additional handouts that you may receive over the course of your care. If you are coming to Integrative Therapies for physical therapy or biofeedback it is recommended that you bring your packet with you to each visit to support continuity of care.

Because we want to provide a thorough assessment and a treatment plan and give you an opportunity to ask questions, there may only be a small amount of treatment time available during your first visit, especially if you are coming for an initial physical therapy or physical medicine evaluation. If you would like to know more about the services offered at Integrative Therapies, please feel free to explore our website. The physical therapy and physical medicine section will provide you with a description of our rehabilitation services and give you a more detailed idea of what is involved in the evaluation process. More extensive information about all of our services can be found in the "Services" section or by clicking on the different icons on the home page.

Our goal is to provide you with a very positive therapeutic experience. As you go through your program, please share any thoughts or recommendations you may have about how we can serve you better. If you have not been scheduled for an orientation with the director directly before or after your initial evaluation, please feel free to contact me personally if you have any questions or concerns.

Finally, I would like to invite you to fill out our Patient Satisfaction Survey available in the reception area toward the completion of your program. We look forward to serving you and appreciate your assistance in enhancing the quality of our care.

Yours in good health,

Lori

Lori Loveland, M.A.
Director

Integrative Therapies & Integrative Pain Management
7E Oak Branch Drive
Greensboro, NC 27407
(336) 294-0910

For office use only
Dx 1: _____ 2:_____
3: _____ 4:_____

Patient Information

Patient Name _____
Address _____
City _____ State _____ Zip _____
Phone: Home _____Cell _____
Email _____
❑ Check here if you would like to receive Email notices on special events.
Age_____Date of Birth _____ Sex _____
Referring Practitioner _____
Other professionals involved in my health care:_____
_____
_____
_____
_____
Have you had physical therapy, occupational therapy or chiropractic care anywhere else within the last year?_____
If so, where and how many visits _____
Date of Injury if applicable_____
Is this a work-related injury? _____

Patient's Employer _____
Address _____
City _____ State _____ Zip _____
Area Code ( ) Phone _____

Emergency Contact _____
Relationship _____
Address _____
City _____ State _____ Zip _____
Area Code ( ) Phone _____

For Injury & Liability Cases:
Attorney Name _____
Address _____
City _____ State _____ Zip _____
Area Code ( ) Phone _____

Billing Information

Party responsible for payment- Same as above ☐
Different- see below: ☐
Address _____
City _____ State _____ Zip _____

Area Code ( ) Phone _____
Patient's Relationship to Responsible Party:

Self ____ Spouse ____ Child/Minor ____ Parent____
Other (specify) _____

Communication/Contact Guidelines Requested by Patient:

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. (Please see HIPAA consent form for more detailed information.)

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone _____
  - ☐ O.K. to leave message with detailed information
  - ☐ O.K. to leave appointment information
  - ☐ Other _____
- ☐ Work Telephone _____
  - ☐ O.K. to leave appointment information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number
- ☐ Other _____
  _____

Signatures are necessary to receive treatment and insurance re-imbursement.

Permission to Treat/Release of Information
I give Integrative Therapies, Inc. permission to treat me and release information/clinical photographs to my insurance company, attorney, treating physicians and/or beneficiaries:
Signature _____Date_____

Assignment of Benefits
I authorize payment directly to Integrative Therapies, Inc. for services I receive.

Signature _____Date_____

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Patient Consent to Use of Protected Health Information (PHI)

Patient Name: _____ Patient DOB _____

This consent form is provided to you and required under the Health Information Portability & Accountability Act of 1996 (HIPAA).

By signing this form, you grant consent to Integrative Therapies, Inc. (we, us, the practice) to use and disclose your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations, subject to our Privacy Policy, which may change from time to time. The following is a summary of our Notice of Privacy Practices. A complete copy is available upon request at our office.

You and we have rights and responsibilities as follows:

1. We will use and disclose your PHI for the purposes of treatment, payment, and to support other related, defined health care operations. These are called "routine disclosures." If you were referred by another healthcare professional we normally send a letter with our findings and plan of care to that practitioner unless you instruct us otherwise (see #6 below).

2. We will keep your PHI confidential, releasing it only according to our policies. In general, we will release your information to others only if we are referring you for care, if your insurer requires release for payment, or if you direct us to do so. In certain situations, for example under State of NC or Federal law, we may be required to release your PHI.

3. You have the right to request to inspect and obtain a copy of the PHI we keep regarding you or regarding someone for whom you are the guardian. We are permitted to charge you a reasonable, cost-based fee for the copy or any additional interpretation of the PHI.

4. You have the right to request that we amend the PHI we keep regarding you or regarding someone for whom you are the guardian.

5. You have the right to request a list of non-routine disclosures of your PHI or the PHI of a person for whom you are the guardian that we have made to other parties after April 14, 2003.

6. You have the right to request that we limit the disclosures of your PHI. We are not required to accept that limit but, if we do so, we will be bound by our agreement with you.

7. You have the right to request specific confidential communications within our office. We are not required to accept that limit but, if we do so, we will be bound by our agreement with you.

8. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance upon your consent previously granted.

Our complete Notice of Privacy Practices is posted in our office and available to you upon request. Our privacy policy is subject to change from time to time. If we change our policy, you may also obtain a copy of the revised Notice by contacting the office.

Signature:_____ Date_____

INTEGRATIVE THERAPIES – FINANCIAL POLICY

Thank you for choosing Integrative Therapies as your health care provider. The following information offers some guidelines regarding our financial policy.

- If you are intending to have insurance claims filed in connection with your therapy at our office, we need to have a copy of your insurance card and a photo ID (Please bring these with you at your first visit).
- Our administrative staff will typically check your benefits prior to your first visit and will submit insurance claims to those companies with which we have contracts and with those companies that offer out-of-network benefits where we do not have a contract.
- As a courtesy, Integrative Therapies will also submit claims for secondary insurance when appropriate.
- Integrative Therapies is not a Medicare or Medicaid provider.
- Please be prepared to pay any co-pays at the time services are rendered.
- Please be prepared to pay any deductible at the time of your visit. If your deductible is particularly cumbersome, one of our administrative staff members will be happy to assist you with a payment plan.
- For those clients that are coming "self pay" (i.e. no insurance is being filed for services) payment is expected at the time that services are rendered.
- Please be aware that you are ultimately responsible for the timely payment of your account. This may include non-covered services not paid by your insurance company.
- A $40.00 fee will be charged for any returned checks.
- Past due accounts of 90 days or more may be subject to collections.
- Except in cases of emergencies, we require a minimum 24 hour notice if you cannot keep your scheduled appointment. We reserve the right to charge for appointments canceled or broken without a 24 hour advance notice. Our fee for missed appointments (those without a 24 hour cancellation) is $45.00 per session hour.
- For your convenience, we accept cash, personal check, MasterCard, Visa, Discover Card and American Express.

If you have any questions regarding our policy, please feel free to ask us. We are here to help you!

I have read and agree to the conditions as outlined: (Please sign and return to clinic)

_____ _____ _____

Name (Printed) Signature Date

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COUNSELING INTAKE

Confidential

Our goal at Integrative is to provide you with excellent services and the following are questions that will help us to understand your treatment needs. This is confidential and we appreciate any information you choose to share.

Name:_____ Date of Birth: _____
Referred by: _____
Current Physician's name: _____ Phone: _____

What lead you to seek counseling and what would you like to accomplish through your counseling sessions?
_____
_____
_____
_____

Please rate your general satisfaction with life at present (circle one):
Very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied

If applicable, please rate your level of satisfaction in present marriage/significant relationship (circle one):
Very dissatisfied 0 1 2 3 4 5 6 7 8 9 10 very satisfied

Your Personal Health
Drug Allergies: __N __ Y (describe)_____
Other Allergies: _____
Significant Health Problems: _____
_____
_____
Surgeries:_____
_____
Current Medications/Herbs/Supplements: _____
_____
_____

Current/Recent Mood (general state):
Anxiety __ Fear __ Sadness __ Grief __ Anger __ Frustrated __ Irritability __ Impatient __
Happy __ Calm __ Numb __

Any changes or concerns involving the following: (Please check those that apply)
Finances ___ Legal Matters ___ Work/Job ___ Education/School ___ Marital Status ____ Relocation ___
Parenting ___ Concentration ___ Memory ___ Energy ___ Grief/Loss ____
Health/Illness ___ Surgery/Injury ___ Addition of a Family Member ___ Sexual Activity ____
Family Member Leaving Home ___ Sleep Habits ____ Social Pressures ____
Eating Habits ____ Caffeine Intake ___ Tobacco Use ___ Alcohol Use ____ Drug Use ____

Extended and Immediate Family History (please check those which apply):
Divorce _____ Alcohol/Substance abuse _____ Physical abuse _____ Sexual abuse _____
Depression _____ Anxiety _____ Suicide _____ Mental Illness _____ Other _____

Other:

Years & Level of Education: _____

Is Spirituality/Religion important to you? _____

_____

Do you attend (or have attended) any Self-Help Groups? No ____ Yes ____(please list) _____

_____

Who do you consider as your greatest ***s***upport?_____

Have family or significant others had counseling or treatment? ___ No ___Yes (describe) _____

_____

_____

Your COUNSELING/PRIOR TREATMENT History:

	No	Yes	When	Where	Your reaction to overall experience.
Counseling/Psychiatric Counseling					
Suicidal thoughts/ attempts					
Drug/Alcohol treatment					
Hospitalizations					
Involvement with self-help groups					

Please check behaviors/symptoms that currently occur to you more often than you would like to take place:

	Aggression		Drug Dependence		Judgment Errors		Thoughts Disorganized
	Alcohol Dependence		Eating Disorder		Memory Impairment		Trembling
	Anger		Elevated Mood		Mood Shifts		Withdrawing
	Antisocial Behavior		Fatigue		Panic Attacks		Worrying
	Anxiety		Fibromyalgia Symptoms		Phobias/Fears		Others (List)
	Avoiding People		Gambling		Recurring Thoughts		
	Chest Pain		Hallucinations		Sexual Addictions		
	Cyber addiction		Heart Palpitations		Sexual Difficulties		
	Depression		High Blood Pressure		Sick Often		
	Disorientation		Hopelessness		Sleeping Problems		
	Distractibility		Impulsivity		Speech Problems		
	Dizziness		Irritability		Suicidal Thoughts		

Briefly describe how the above symptoms impair your ability to function effectively: _____

_____

Any current suicidal thoughts/plan? ___No ___Yes (describe) _____

_____

_____

Any additional information that would assist us in understanding your concerns or problems? _____

_____

_____