INTEGRATIVE THERAPIES

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

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

If you are planning to receive QEEG or neurofeedback services at Integrative Therapies, please fill out the three accompanying forms and bring them with you to your appointment. These are basic administrative forms and do not include any of the clinical questionnaires that will be important for brain mapping and neurofeedback.

One of our neurofeedback practitioners will be in contact with you to give you guidance on how to prepare for your assessment and to fill out the necessary forms to get started. Most of the information and questionnaires can be found by logging on to the website: https://www.My-NewMind.com . Expect to receive instructions on creating an account on this private and secure website in person or by email. Please feel free to contact us at the number above if you have any questions or concerns. We look forward to seeing you soon!

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_____

Integrative Therapies
7E Oak Branch Drive Greensboro, NC 27407

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**