INTEGRATIVE
CENTER for THERAPY

Instructions for filling out your Integrative Center for Therapy Patient forms.

Acrobat Reader is needed to use the auto-fill feature on this form. If you do not wish to use auto-fill on your computer, you may still print out the form, manually fill in your answers and bring to our office at your first appointment.

If you do not have Acrobat Reader or a .pdf reader, please go to https://get.adobe.com/reader/otherversions/ to download a free version of Acrobat Reader to your computer.

Once you have downloaded and installed Acrobat Reader, please download the Patient Forms file to your desktop. Once you open and read the file, you will see the fill-able information fields.

Once you have filled in all of your answers and entered your name in all of the required signature boxes, please save this file and email it to: ictphysicaltherapy@gmail.com

Thank you

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. INTEGRATIVE CENTER FOR THERAPY IS COMMITTED TO PROTECTING THE PRIVACY OF YOUR INFORMATION AND WE ENCOURAGE YOU TO CONTACT OUR PRACTICE FIRST IF ANY ISSUE OR QUESTIONS ABOUT YOUR PRIVACY ARISE.

We are required by law to maintain the privacy of Protected Health information and to give you this notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health to you, or (3) the past, present, or future payment for your health care.

How May We Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **Research.** We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare

for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact and individual.

- **As required by law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosure to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse and neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breech Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization: 1. Most uses and disclosures of psychotherapy notes; 2. Uses and disclosures of Protected Health Information for marketing purposes; and 3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs- based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternate form and pay the associated fees.
- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as the electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost- based fee for the labor associated with transmitting the electronic medical record.

- **Right to get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the address provided at the beginning of the Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charger you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the privacy officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.
- **Out-of-Pocket-Payments**. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise your Rights

To exercise your rights described in this notice, send your request, in writing, to our privacy officer at the address listed at the beginning of this notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this notice. We reserve the right to make the changed Notice effective for Protected Health Information we create or receive in the future. A copy of our current notice is posted in our office.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint. To file a complaint with the secretary, mail it to: Secretary of the U.S Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Effective Date: October 24, 2015 This notice was revised on: April 30, 2021

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT US:

Kristen Fields
Mailing Address: 223 S. Hillside, Wichita, KS 67211
Telephone: 316-691-8885
Cell: 620-218-5193
Fax: 316-619-8866
Email: ictphysicaltherapy@gmail.com

INTEGRATIVE
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Notice of Privacy Practices

Dear Patients,

Although our office has always treated medical records as confidential, our government now wants you to receive a written copy of how this office protects your health records. Please take your written copy of our privacy practices home with you and read it at your convenience. In addition, please sign this acknowledgment form indicating that we have provided this information to you.

Thank you,

Integrative Center for Therapy

I hereby acknowledge that I have received a copy of this Clinic's Notice of Privacy Practices.

Patient name:_____ Date of Birth:_____

Signature:_____ Date:_____

Relationship:_____

☐ This patient received NPP and refused to acknowledge receipt at this time.

Employee Signature:_____ Date:_____

This is a permanent part of this medical record and shall be retained with the chart. If records are thinned this form remains a part of the primary record.

Demographics
Last Name_____ First Name_____ MI_____
SS#_____ DOB_____ Age_____ Sex_____
Address_____
Phone: Home_____ Cell_____
Employer_____ Work_____

Emergency Contact
Name_____ Relationship_____
Phone #'s_____

Guarantor
Last Name_____ First Name_____ MI_____
Address_____
Relationship to Pt._____ DOB_____
Phone#_____

Primary Health Insurance
Insurance_____ Group#_____
ID#_____ Effective Date_____
Name on Plan_____ DOB_____

Secondary Health Insurance
Insurance_____ Group#_____
ID#_____ Effective Date_____
Name on plan_____ DOB_____

Referring Physician_____
City/State_____
Physician Phone_____

Signature_____ Date_____

INTEGRATIVE
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PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONAIRE

Patient History and Symptoms

Your answers to the following questions will help is to manage your child's care better. Please complete all pages **prior to** your child's appointment.

Name of parent or guardian completing this form:_____
Child's Name: _____ Prefers to be called: _____
Date:_____ Age:_____ Grade: _____ Height:_____ Weight: _____
Describe the reason for your child's appointment: _____
When did this problem begin? _____ Is it getting better_____ Worse_____ staying the same_____
Name and date of child's last doctor visit_____ Date of last urinalysis_____
Previous tests for the condition for which your child is coming to therapy. Please list tests and results:

_____
_____
_____

Medications	Start date	Reason for taking

Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can't go to sleep overs, feels ashamed about leakage and avoids play dates?

_____
_____

Does your child now have or had a history of the following? Explain all selected responses below.

- ☐ Pelvic Pain
- ☐ Low back pain
- ☐ Diabetes
- ☐ Latex Sensitivity/allergy
- ☐ Allergies
- ☐ Asthma
- ☐ Surgeries
- ☐ Blood in urine
- ☐ Kidney infections
- ☐ Bladder infections
- ☐ Vesicoureteral reflux Grade:_____
- ☐ Neurologic (brain, nerve) problems
- ☐ Physical or sexual abuse
- ☐ Other (please list)_____

Explain your responses and include dates:

_____
_____

Please check if your child need to be catheterized? ☐ If yes, how often?

_____

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Bowel and Bladder Habits

1. Have often does your child urinate during the day? _____ times per day, every _____ hours.
2. How many times per week does your child have a bowel movement?
3. Does your child have the sensation (urge feeling) that they need to:
   - Urinate ☐ -Poop ☐
4. How long does your child delay going to the toilet once he/ she needs to pee/poop? (check one)
   - ☐ Not at all
   - ☐ 1-2 minutes
   - ☐ 3-10 minutes
   - ☐ 11-30 minutes
   - ☐ 31-60 minutes
   - ☐ Hours
5. Does your child take time to go to the toilet and empty their bowel/ bladder? Y/N
6. Does your child have difficulty initiating a bowel movement? Y/N Urine void? Y/N
7. Does your child strain to poop? Y/N Does your child strain to pee? Y/N
8. Does your child have smearing or bowel accidents? Y/N If yes, how many times per day? ____
9. Does your child wet the bed? Y/N If so, How often? _Every night _ 3-6 nights _ 0-2 nights

Other Health History:

Birth history: Did your child have a normal birth? Y/N
Was your child born Full Term? Y/N If no, how many weeks early? _____
Was the delivery: Vaginal or C-section
Did your child develop normally? Y/N Meet motor milestones on time? Y/N
If not, can you give additional information regarding development? _____
_____
_____
_____

Other medical history:
Does your child have any other medical diagnosis? Please list: _____
_____
_____

Does your child see any specialists? Y/N If so, please explain:
_____
_____

Is there anything else that wasn't listed, that you feel is important to the treatment of your child? _____
_____
_____
_____

INTEGRATIVE
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Patient Self-Referral and Insurance Billing Policies

As of July 1, 2013 according to the State of Kansas Physical therapy Practice Act, Statue 65-2921 states that patients may refer themselves to a physical therapist without a referral from their physician or other health care provider. As stated in this statute it is our responsibility to inform you that at the conclusion of an initial evaluation, we will not be providing you with a medical diagnosis but rather a physical therapy diagnosis but rather a physical therapy diagnosis and appropriate physical therapy goals to work towards in future physical therapy visits.

In the event that you do not make measurable progress towards the physical therapy goals set by you and your physical therapists within 10 visits or 15 business days after your second visit with your physical therapist we are then required by law to receive a referral from an appropriate “licensed health care practitioner” to continue your physical therapy plan of care. A “licensed health care practitioner” means a person licensed to practice medicine and surgery, a licensed podiatrist, a licensed physician assistant or a licensed advanced practice registered nurse working pursuant to the order or direction of a person licensed to practice medicine and surgery, a licensed chiropractor, a licensed dentist or licensed optometrist in appropriate related cases.

We will be glad to file the services we provide through your insurance company. Insurance companies require that the services billed to them on your behalf are medically necessary. Physical therapy, as part as part of an individual’s health care, is considered medically necessary as determined by the licensed physical therapist based on the results of a physical therapy evaluation and when provided for the purpose of preventing, minimizing, or eliminating impairments, activity limitations, or participation restrictions. Insurance companies do not consider maintenance to be medically necessary. Therefore, if you have met your physical therapy goals set by you and your physical therapist and your physical therapist does not feel that further progress is possible, then we will have to discontinue billing your insurance for our services. We would be glad to continue seeing you to help you maintain your progress; however, it will have to be as a cash-based maintenance program that you will be responsible for paying out-of-pocket for. It is our job to provide you with the best care possible but we are also legally and ethically responsible to be good stewards of health care costs and insurance billing practices.

We thank you for the opportunity to provide you quality health care and will look forward to working towards your physical therapy needs. Please remember your physical therapist is available to you in the future if you experience a reoccurrence of your current problem or if any other musculoskeletal, movement, or functional impairment occurs that causes you pain or limits your ability to perform the necessary tasks within your life.

Cancellation and No Show Policy

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

ALL missed appointments will be attempted to be rescheduled the same week so you may fully recover.

Integrative Center for Therapy requires 24 hour advance notice for any cancellation. If you are unable to give 24 hour advance notice or you do not show for your scheduled appointment an administrative fee of $60/half hour or $80/hour appointment will be billed to you.

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.

_____ _____

Patient Signature Date

INTEGRATIVE
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PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it will be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. The examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. The evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region. Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist. They may experience an increase in current symptoms, however this may be a side effect of treatment.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records: I authorize the release of medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists and therapy assistants and technicians of

Date_____ Patient Name: _____

_____ _____

Patient signature Signature of Parent or Guardian (If applicable)

_____

Witness Signature