

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of treating physician _____ Dates of treatment _____
 Type of treatment or drugs prescribed _____

Name of treating physician _____ Dates of treatment _____
 Type of treatment or drugs prescribed _____

Please list all past surgeries:

Type _____	When _____
Type _____	When _____
Type _____	When _____
Type _____	When _____

- | | |
|---|---|
| ▶ Have you ever suffered a stroke? Y N | ▶ Anyone in your family had a stroke? Who/Age _____ |
| ▶ Have you ever had a heart attack? Y N | ▶ Anyone in your family had a heart attack? Who/Age _____ |
| ▶ Do you have vascular disease? Y N | ▶ Anyone in your family have vascular diease Who/Age _____ |
| ▶ Do you have high blood pressure? Y N | ▶ Anyone in your family have high blood pressure? Who/Age _____ |
| ▶ Do you smoke? Y N How much? _____ | ▶ Have you ever smoked in the past? Y N How much? _____ |
| ▶ Do you take birth control pills? Y N | ▶ Have you ever taken birth control pills? Y N |

Barre Leiou + -

George's Test + -

Please list any medications or vitamins you are currently taking:

- | | |
|--|---------------------------------------|
| ▶ When was your last Visit to the chiropractor? _____ | ▶ Were you helped? Y N |
| ▶ What spinal correction program were you given? _____ | |
| ▶ Did you follow it? _____ | ▶ How did the post x-rays look? _____ |

Please mark X for present conditions, O for past conditions

- | | | | |
|------------------------------|--------------------------------|---|----------------------------|
| ____ Fractured bones | ____ Sinus Problems | ____ Fainting | ____ Varicose Veins |
| ____ Auto Accidents | ____ Eating Disorders | ____ Loss of Balance | ____ Liver Trouble |
| ____ 0-1 year ago | ____ Trouble Sleeping | ____ Blurred vision R L | ____ Gall Bladder Trouble |
| ____ 1-5 years ago | ____ Trouble Concentrating | ____ Double Vision R L | ____ Digestive Problems |
| ____ more that 5 years ago | ____ Learning Disability | ____ Upper Back Pain/Stiffness | ____ Heartburn |
| ____ Other accidents/ Falls | ____ Mood changes | ____ Mid back Pain/Stiffness | ____ Ulcers |
| ____ Back curvature | ____ Headache | ____ Low BackPain/Stiffness | ____ Diarrhea/Constipation |
| ____ Arthritis | ____ Pain/Stiff Neck R L | ____ Numbness, Tingling or Pain | ____ Colon Trouble |
| ____ Diabetes | ____ Numbness/Tingling/Pain | ____ in buttocks, thighs, legs, feet, toes. | ____ Hemorrhoids |
| ____ Swollen/Painfull joints | ____ Arms/Hands/Fingers | ____ Pain with cough/sneeze | ____ Prostate Problems |
| ____ Convulsions/Epilepsy | ____ R L | ____ Hip Pain R L | ____ Impotence |
| ____ Skin Problems | ____ Jaw Pain/ TMJ R L | ____ Foot Trouble R L | ____ Kidney Trouble |
| ____ Cancer | ____ Head/Shoulders Feel Tired | ____ Chest Pain | ____ Menstrual Problems |
| ____ Frequent Colds/Flu | ____ Difficulty in Excessive | ____ Asthma | ____ Menopausal Problems |
| ____ Depressed | ____ Standing Lifting | ____ Lung Problems | ____ Pregnant (Now) |
| ____ Irritable | ____ Walking Household duties | ____ Difficulty breathing | ____ Bed Wetting |
| ____ Anemia | ____ Bending Twisting | ____ Heart Problem | ____ Ear Infection |
| ____ Tremors | ____ Riding | ____ Stroke | ____ AIDS/HIV |
| ____ Allergies | ____ Shoulder Pain R L | ____ High/Low Blood Pressure | ____ Last Menstrual Period |

AUTOWORK RELATED INJURY NEW PATIENT QUESTIONNAIRE

Date of Birth _____ Age: _____ S.S. # _____
Last Name _____ First Name _____
Address _____ Apt # _____
City _____ State _____ Zip Code _____
Phone (H) _____ (W) _____ (C) _____ E-mail _____
Contact in case of an emergency _____ Phone # _____ Relationship _____
Your Occupation _____ Employer _____
FEMALES: Are you pregnant? ___ No ___ Yes If yes, How many weeks? ___ Date of last menstrual cycle? _____

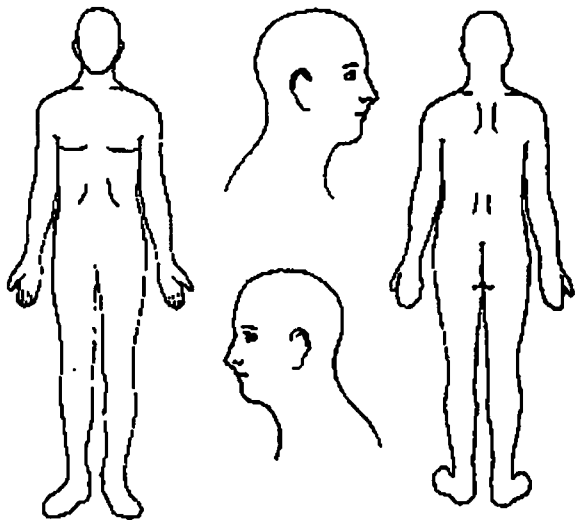
If patient is a minor (under 18 y/o), please fill out this section. If not, skip this box.

Parent/Guardian's Name _____ Relationship _____ DOB: _____ Age _____
Address _____ Apt # _____
City _____ State _____ Zip Code _____
Phone (H) _____ (W) _____ (C) _____ E-mail _____
Occupation _____ Employer _____

WHAT BRINGS YOU TO THIS OFFICE?

FIRST COMPLAINT

- ▶ Date when symptoms first appeared: _____ ▶ Have you had this condition before? Y N
- ▶ Is this condition related to : Work Auto Date of accident: _____ Have you lost days from work? Y N
- ▶ Did it begin Gradual Y N Sudden Y N How many days? _____
- ▶ What makes the symptom increase? _____
- ▶ What relieves the symptoms? _____
- ▶ Type of pain ___ Sharp ___ Dull ___ Aching ___ Burning ___ Throbbing
- ▶ Does the pain radiate into your L R Shoulder-Arm-Hand L R Buttocks-Leg-Foot ___ Does not radiate
- ▶ Do you experience numbness and tingling? Y N How often do you get pain? 100% 75% 50% 10%



Place an "X" on the drawing on areas causing you pain and a letter describing it

S = STABBING
N = NUMBNESS
B = BURNING
A = ACHING
P = PINS & NEEDLES

PAIN INTENSITY

Please circle the number that best describes your pain
0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

Patient Signature _____

OTHER COMPLAINT

- ▶ Date when symptoms first appeared: _____ ▶ Have you had this condition before? Y N
- ▶ Did it begin Gradual Y N Sudden Y N How many days? _____
- ▶ What makes the symptom increase? _____
- ▶ What relieves the symptoms? _____
- ▶ Type of pain ___ Sharp ___ Dull ___ Aching ___ Burning ___ Throbbing
- ▶ Does the pain radiate into your L R Shoulder-Arm-Hand L R Buttox-Leg-Foot ___ Does not radiate
- ▶ Do you experience numbness and tingling? Y N How often do you get pain? 100% 75% 50% 10%

PAIN INTENSITY

Please describe the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10
 NONE LITTLE MEDIUM SEVERE

If you have additional complaints to address with the doctor, please let the front desk know. They will give you an additional form.

PREVIOUS ACCIDENT HISTORY

Have you ever been involved in another motor vehicle accident?

Yes No Please describe briefly with dates: _____

PRESENT ACCIDENT HISTORY

Date of accident: _____

Street and Address: _____

Were any tickets issued and to whom? _____

Please indicate if you were the/at: Driver

Front seat Back seat L or R Other

Did the impact to your vehicle come from the: Front Rear

Right Side Left side Did the air bag deploy? Yes No

Did you hit anything inside the vehicle? No Yes

If yes, describe: _____

Did you experience immediate pain? No Yes

Did the ambulance/paramedics arrive at the scene? Yes No

Were you taken to the hospital? No Yes

Did you drive to the hospital? No Yes

If yes, which hospital? _____

Were x-rays taken? No Yes

Did they prescribe any medication? No Yes

Are you currently taking other medication? No Yes

If yes, please name: _____

Please briefly describe the accident in your own words:

SOCIAL HISTORY

▶ Do you drink alcohol? No Yes

If yes how much? _____

▶ Do you use tobacco (smoke or chew)?

No Yes How much? _____

▶ Do you use any other drugs?

No Yes If yes, how much

and which ones? _____

Please if you have experienced any of the following since this accident

Nausea Neck Pain

Vomiting Mid-Back Pain

Ringing in ears Low-Back Pain

Headaches Dizziness

Changes in vision Brain Fog

Difficulty swallowing Numbness

Difficulty talking Tingling

Difficulty with balance Other

Hand/Arm/Shoulder Pain

Buttox/Leg/Foot Pain

Bowel/Bladder difficulty

Doctor's Name: _____

Signature: _____

Date: _____

Integrative Physical Medicine, Inc.
 425 Alexandria Blvd. Ste. 1010 Oviedo, FL 32765
 Phone 407-977-3434
 Fax 407-977-3433

REVIEW OF SYSTEMS

This information may be addressed on other forms in addition to this one. This is for insurance purposes. Please fill it out completely.

PATIENT'S NAME: _____

DATE: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GENERAL INFORMATION:		
Any recent weight gain/loss	Y	N
Weakness	Y	N
Fatigue	Y	N
Fever	Y	N
Fainting spells	Y	N
Nausea	Y	N
Vomiting	Y	N
Balance problems	Y	N
Jaw pain	Y	N
Neck Pain	Y	N
Neck Stiffness	Y	N
Shoulder Pain	Y	N
Arm Pain	Y	N
Wrist /Hand Pain	Y	N
Numbness arms or hand	Y	N
Upper back pain	Y	N
Lower back pain	Y	N
Hip pain	Y	N
Leg Pain	Y	N
Ankle /Foot Pain	Y	N
Numbness Legs or Feet	Y	N
Joint swelling	Y	N
Tension	Y	N
Nervousness	Y	N
Anxiety	Y	N
Irritability	Y	N
Sleeping Problems/Insomnia	Y	N
Depression	Y	N
Liver problems	Y	N
Cancer (if yes indicate what type)		
Metal implants	Y	N
If yes Indicate where: _____		

HEAD	
Headaches	Y N
Loss of consciousness	Y N
Dizziness	Y N
Memory problems	Y N
Seizures/Convulsions	Y N

EYES	
Wear Glasses/Contact Lenses	Y N
Double vision	Y N
Blurred Vision	Y N
Eyes sensitive to light	Y N

EARS	
Loss of hearing	Y N
Ringin/Buzzing in ears	Y N
Ear infections	Y N
Vertigo (Dizziness)	Y N
Any discharge from ears	Y N

NOSE	
Sinus Problems	Y N
Epitaxis (Nosebleeds)	Y N
Loss of smell	Y N
Any discharge form nose	Y N

MOUTH/THROAT	
Tooth Pain	Y N
Any Lesion/Sores in mouth or lips or gums	Y N
Frequent sore throats	Y N
Difficulty swallowing	Y N
Thyroid problems	Y N

RESPIRATORY (LUNG)	
Difficulty Breathing	Y N
Chronic Cough	Y N
Asthma	Y N
Bronchitis	Y N
Emphysema	Y N
Tuberculosis	Y N
Pneumonia	Y N

Date of last chest x-ray	

CARDIOVASCULAR(HEART)	
Chest Pain	Y N
Difficulty Breathing (Shortness of Breath)	Y N
Palpitations	Y N
Night sweats	Y N
Cold extremities	Y N
High blood Pressure	Y N
Low Blood Pressure	Y N
Heart Murmur	Y N
Ever had an EKG/ECG	Y N

GI (Gastrointestinal)	
Upset stomach	Y N
Loss of appetite	Y N
Indigestion	Y N
Constipation	Y N
Diarrhea	Y N
Blood Stool	Y N
Abdominal Pain	Y N
Excessive Gas	Y N
Loss of bowel control	Y N

ENDOCRINE	
Cold or Heat intolerance	Y N
Excessive sweating	Y N
Excessive thirst or hunger	Y N
Diabetes (If yes indicate If Insulin dependent)	Y N

Thyroid problems	Y N
Kidney Problems	Y N

GU(GENITOURINARY)	
FEMALES	
History of Pelvic Inflammatory Disease	Y N
Urinary Tract Infections	Y N
Breast Cancer &/or Benign Tumors	Y N
Blood in Urine	Y N
Painful urination	Y N
Vaginal discharge	Y N
PMS	Y N
Loss of Bladder Control	Y N
Currently pregnant	Y N
Use Birth Control Pills	Y N
Date of last menstrual period	_____
If indicated age of menopause	_____
Last Pelvic Exam (Date and Results)	_____
Last Pap Smear (Date and Results)	_____
Last Breast Exam (Date and Results)	_____
Any Sexual transmitted disease (STDs)	Y N
MALES	
Prostate Problems	Y N
Hernias	Y N
Penile Discharge	Y N
Blood in urine	Y N
Frequent urination	Y N
Testicular pain	Y N
Loss of bladder control	Y N
Last Prostate Exam (Date and Results)	_____
Last PSA Date and Results	_____
Any Sexual transmitted disease (STDs)	Y N

PATIENT SIGNATURE :
 X _____

DATE:
 X _____

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: _____ File # _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4-WALKING

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5-SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more 10 minutes.
- I avoid sitting because it increases pain right away.

SECTION 6-STANDING

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than 1/4.
- Because of pain, my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9-TRAVELLING

- I get no pain while travelling.
- I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while travelling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates, but is definitively getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

The Neck Disability Index

Patient name: _____ File# _____ Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally, without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4-READING

- I can read as much as I want to, with no pain in my neck.
- I can read as much as I want to, with slight pain in my neck.
- I can read as much as I want to, with moderate pain in my neck.
- I can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read at all.

SECTION 5-HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6-CONCENTRATION

- I can concentrate fully when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7-WORK

- I can do as much work as I want to.
- I can do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

SECTION 8-DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want, with slight pain in my neck.
- I can drive my car as long as I want, with moderate pain in my neck.
- I can't drive my car as long as I want, because of moderate pain in my neck.
- I can hardly drive at all, because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9-SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- I am able to engage in all my recreation activities, with no neck pain at all.
- I am able to engage in all my recreation activities, with some neck pain at all.
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- I am able to engage in few of my recreation activities, because of pain in my neck.
- I can hardly do any recreation activities, because of pain in my neck.
- I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Dr. Marc G. Ott

RECORDS RELEASE AUTHORIZATION

DATE: _____

To Doctor or Hospital

Name: _____

Phone # _____

Address: _____

Fax # _____

I hereby authorize and request release to:

**Integrative Physical Medicine, Inc.
425 Alexandria Blvd. Ste. 1010
Oviedo FL, 32765
407-977-3434**

The complete history records in your possession, concerning my illness and/or treatment during the period

From: _____

To: _____

Patient: _____

SS # _____

D.O.B. _____

Date of Injury or Illness: _____

Patient's Signature: _____

Date: _____

Witness: _____

Date: _____

THIS FAX IS INTENDED ONLY FOR THE USE OF THE PERSON OR OFFICE TO WHOM IT IS ADDRESSED, AND CONTAINS PRIVILEGED OR CONFIDENTIAL INFORMATION PROTECTED BY LAW. ALL RECIPIENTS ARE HEREBY NOTIFIED THAT INADVERTENT OR UNAUTHORIZED RECEIPT DOES NOT WAIVE SUCH PRIVILEGE, AND THAT UNAUTHORIZED DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE DESTROY THE ATTACHED DOCUMENT (S) AND NOTIFY THE SENDER OF THE ERROR BY CALLING 407-977-3434. IF YOU DO NOT RECEIVE ALL OF THE PAGES, OR IF YOU HAVE ANY PROBLEMS WITH THIS TRANSMISSION, PLEASE CALL 407-977-3434

425 Alexandria Blvd. Ste. 1010 Oviedo FL , 32765 P. 407-977-3434 F. 407-977-3433
www.integrativephysicalmed.com

**Integrative Physical Medicine, Inc.
Dr. Marc Ott**

To: _____

Patient: _____

RE: HEALTH RECORDS AND PROVIDER'S LIEN

I do hereby authorize the above provider, Integrative Physical Medicine, Inc., to furnish you, my attorney, with a full report of this examination, diagnosis, treatment, prognosis, etc., of myself in regard to the injury in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Integrative Physical Medicine, Inc. such sums as may be due and owing them for medical service rendered me both by reason of this injury and by reason of any other bills that are due their office and withhold sums from any settlement, judgment or verdict as may necessary to adequately protect said provider. And I hereby further give a lien on my case to said company against any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries for which I have been treated or injuries in connection herewith.

I full understand that I am directly and fully responsible to said provider for all medical bills submitted by them for services rendered me and that this agreement is made solely for said provider's additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I forbid you, my attorney, from paying my provider any sums less that the full amounts owed to said provider, without its written consent.

Dated: _____ Patient's Signature: _____

The undersigned being attorney of record for this above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may necessary to adequately protect said providers above named.

Dated: _____ Attorney's Signature: _____

Please date, sign and return one copy to Provider's office. Keep a copy for your records. A photocopy of this form shall be considered as valid as the original.

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

I hereby give my consent for Integrative Physical Medicine, Inc. (hereinafter referred to as the "Practice") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practice any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

**Dr. Marc G. Ott, our Privacy Officer, at the following address:
425 Alexandria Blvd. Ste 1010, Oviedo FL, 32765**

With this consent, the practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care.

With this consent, the Practice may mail to my home or other alternative location any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, The Practice may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carryout TPO, however; the practice is not required to agree to my requested restrictions. If The Practice does agree to my requested restrictions, it is bound by this agreement.

By signing this form, I am consenting to The Practice's use and disclosure of my PHI to carry out TPO. In addition, I allow Integrative Physical Medicine, Inc. to contact me by any of my phone numbers, postal mail or email and leave me a message if necessary.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, or later revoke it, The Practice may decline to provide treatment to me.

Patient's Name

Signature of Patient or Legal Guardian

Print Name of Legal Guardian (if patient is a minor)

Date

OFFICE POLICIES

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There may be a fee for copying of the x-rays.
3. If you have any out of pocket responsibility what will be your method of payment?

Cash Check Credit Card/Debit Card Attorney /Letter of Protection.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and my self. Furthermore, I understand Integrative Physical Medicine, Inc. will prepare any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Integrative Physical Medicine, Inc. will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered to me, are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

Print Patient Name: _____ Date: _____

Patient/Guardian Signature authorizing care: _____ Date: _____

In case of emergency notify: _____ Relationship: _____

Address: _____ City: _____

State: _____ Phone Number: _____

Integrative Physical Medicine, Inc.
Dr. Marc Ott

SIGNATURE ON FILE

Please initial by each:

_____ I authorize use of this form on all my insurance submissions

_____ I authorize release of information to all my Insurance Companies

_____ I understand that I am responsible for my bill

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies

_____ I authorize payment directly to my doctor

_____ I permit a copy of this authorization to be used in place of the original

(NAME)

(S.S. #)

(SIGNATURE)

(DATE)