Patient Information Consent Form

Occupational therapists help people of all ages, race, and religion to improve their ability to perform tasks in their daily living and working environments. They treat injured, ill, or disabled individuals through the therapeutic use of everyday activities in order to help patients develop, recover, improve, and maintain the skills needed for daily living and work tasks.

Individualized Quality Therapy, LLC uses assessment and intervention to develop, recover, or maintain meaningful activities (occupations) by creating a personalized treatment plan for each patient. We believe that all of our patients deserve an individualized therapy program that promotes the best outcomes to get you back to doing what you love and need to do.

The purpose of occupational therapy is to treat injury, disability, and disease by examination, evaluation, diagnosis, and intervention. Rehabilitative procedures commonly used are mobilization, physical agent modalities, manual therapy, therapeutic exercises, therapeutic activities, neuromuscular re-education, and patient education. These aid the patient in achieving their maximum potential in the least amount of time for recovery. All procedures will be thoroughly explained to you before you are asked to demonstrate them.

Response to therapy intervention varies from person to person; therefore it is not possible to predict your response to a modality, procedure, activity, or exercise. Individualized Quality Therapy, LLC does not guarantee what your reaction will be to a specific treatment approach, nor does it guarantee that occupational therapy treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the occupational therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to discuss medical concerns with your occupational therapist. You have the right to discuss with your occupational therapist any questions or concerns you may have with your treatment. You have the right to decline any portion of your treatment at any time or during your treatment sessions.

I have read this consent form and understand the risks involved in occupational therapy and agree to fully cooperate, participate in my treatment plan, and comply with the established plan of care. I authorize the release of my medical information to the appropriate third parties.

____________________	____________________	____________________
Patient Name	Patient Signature	Date

836 Centennial Way Ste 160 Lansing, MI 48917

Patient Information

Name________________________________Date of Birth____________ Age_____

Gender___________Height _________ Weight________ Hand Dominance____________

Martial Status______________________________ Today's Date_______________

Address____

City_______________________________State___________Zip_______________

Phone____________________Mobile__________________Work_______________

Email____

Employer/School________________________Occupation/Sport________________

Employer Address__________________________________ Employer Phone________

Insurance Company____________________ Policy Holder Name________________

Policy Holder Relationship to Patient_______________ & Employer _____________

Policy Holder's Address____

Policy Holder Date of Birth______________ Policy Holder's SS#_________________

Enrollee ID______________________ Group Number__________________________

How did you hear about Individualized Quality Therapy, LLC?___________________

Referring MD____

Seeking treatment for?____

Pain Onset(injury)______________________Date of Surgery____________________

Emergency Contact________________________________Phone__________________

Parent or Guardian___________________________Relationship________________

******24 Hour Cancellation Policy: Please provide 24 hour notice in order to reschedule or cancel your appointment. Note that your appointment time is reserved specifically for you; hence, late cancellations without valid reason will be charged a cancelation fee of $30.00 at the beginning of your next appointment.*******

______________________	______________________	______________________
Patient Name	Patient Signature	Date

Financial Policy and Disclosure

Patients are responsible for the payment of all services provided by Individualized Quality Therapy, LLC.

Self-Pay Policy: If you are a self-pay patient, you will be required to pay for each treatment session before services are rendered.

Insurance Policy: If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information. If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service. Deductibles, co-payments, and coinsurance will be collected before services are rendered.

Worker's Compensation Policy: If you are a worker's compensation patient, it is our policy to bill your employer or worker's compensation carrier for services rendered. If payment is denied by worker's compensation, you will become the responsible party for the balance of your services rendered. It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.
**I hereby authorize Individualized Quality Therapy LLC to speak to my employer, my insurance carrier or other professionals involved in my care, regarding my medical records and the treatment I have received of will receive.

I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered services. If I am uninsured, I agree to pay for medical services rendered to me at time of service.

I hereby authorize and direct payment of my medical benefits to Individualized Quality Therapy, LLC on my behalf for any services furnished to me by the providers. I hereby authorize Individualized Quality Therapy, LLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis, examinations, and treatments rendered to me needed to substantiate payment for such medial services as well as information required for precertification, authorization or referral.

Medicare Request for Payment: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Individualized Quality Therapy, LLC. I authorize any holder of medial or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

Patient Name	Patient Signature	Date

Individualized Quality Therapy

Specializing shoulder to fingertip

Certified Hand Therapy: Occupational Therapy

517-798-3677 Lansing, MI

Health Questionnaire

1. What condition are you seeking treatment for? ____________________
2. Have you ever had therapy for this condition before? ____________________
3. What health concerns do you have, including but not limited to, diabetes, high blood pressure, heart disease, trouble with vision, nerve/sensation problems, etc?____________________
____
4. Do you have any metal implanted in your body? ____________________
5. Do you have a pacemaker? ____________________
6. Are you or could you may be pregnant? ____________________
7. Are you taking any medications? __________If yes please list, ____________________
____
8. Please select any of the following you have received for this condition with dates if known.

__X-Ray: ________ __MRI: ________ __EMG: ________ __CT Scan: ________

Other: ____________________

9. Pain Level: with 0/10 being no pain at rest to 10/10, you are in need of an ER
   Current______ Best _______ Worst _______
10. Other Medical Conditions or surgical procedures: ____________________
____
11. Hobbies: ____________________

**I voluntarily consent to any and all treatment procedures provided by Individualized Quality Therapy, LLC. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Individualized Quality Therapy's Notice of Privacy Practices. I authorize payment of medical benefits to Individualized Quality Therapy, LLC or their designee for services rendered.

____________________ ____________________ ____________________

Patient Name Patient Signature Date

836 Centennial Way Ste 160 Lansing, MI 48917

Patient Information Consent Form (HIPAA)

I have read and fully understand Individualized Quality Therapy, LLC's Notice of Information Practices. I understand that Individualized Quality Therapy LLC may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment.

I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Individualized Quality Therapy, LLC will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Individualized Quality Therapy, LLC's Notice of Information Practices.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I, ______________________________, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:

Name:____

Relationship:______________________

Name:____

Relationship:______________________

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

______________________	______________________	______________________
Patient Name	Patient Signature	Date

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Individualized Quality Therapy
Specializing shoulder to fingertip
Certified Hand Therapy; Occupational Therapy
517-798-3677 Lansing, MI

IASTM information and Waiver

At Individualized Quality Therapy your treatment may include manual therapy techniques. Manual therapy focuses on problem areas that are tender to the touch or are tender with movement, that are lacking mobility, or tissue built up regions. It focuses on minimizing pathology while improving function. At times, there may be a chance that Individualized Quality Therapy, LLC therapists may use a tool to help manipulate tissue in order to gain an outcome, such as: decreased pain, decreased scar tissue formation, or improved movement of a muscle.

IASTM (Instrument Assisted Soft Tissue Manual) focuses on trigger points, tender tissue, and deep layers of scar formation; areas that are difficult to reach with the therapists hands alone.

-What does it do?

It causes an inflammatory response to the area focused on to promote nutrient rich blood cells and enhance healing while minimizing pain.

-What can I expect during the treatment?

At the time of service, the area may be tender, which is a normal response, but let your therapist know if the technique becomes too sore or uncomfortable. During IASTM, you may experience increased pain, warmth, redness or a raspberry type rash skin response.

-What can I expect after treatment?

Later that day, you may still have the skin rash, possible bruising, and tenderness with movement or palpation (*Note: not all people have a response that persists).*

-Why is this treatment worth the potential effects?

IASTM is a specialized treatment technique that stimulates nutrient rich blood flow, enhances performance of the targeted muscles, and improves functional use of the body part with less pain. Effects can last long term with the appropriate amount of treatment sessions.

Please answer the following questions to help us best create an appropriate treatment plan for you.

1. Do you bruise easily? YES NO
2. Do you bleed for long periods of time when you cut yourself? YES NO
3. Are you taking blood thinners or anticoagulants? YES NO
4. Do you take aspirin or baby aspirin on a regular basis? YES NO
5. Have you had any blood clots? YES NO
6. Do you have any surgical implants in your body? YES NO
7. Do you have diabetes or a kidney disease? YES NO
8. Do you currently have any infections? YES NO

I understand all the possible outcomes of IASTM techniques and understand that I can opt out of any treatments at any time, may they become uncomfortable for me by verbalizing my needs to my therapist. I consent to IASTM if my therapist deems it necessary for my treatment.

Patient Name	Patient Signature	Date

836 Centennial Way Ste 160 Lansing, MI 48917

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Computer Reminder Agreement

You are able to enroll in automated reminders from the computer system. However, if you need to cancel or reschedule an appointment for any reason, you must call or text 517-798-3677. Replies to the automated system do not go through and you will not be able to use this system as a means for canceling or rescheduling your appointments.

*****Please note that if you sign up for automated responses and attempt to cancel through a reply to the computer, you may be charged the $30 fee for a missed or late canceled appointment.***

~I, ______________________________ would like to receive text reminder from the automated computer system.

~I, ______________________________ would like to receive an email reminder from the automated computer system.

~I, ______________________________ do not wish to receive reminders from the automated computer system.

______________________	______________________	______________________
Patient Name	Patient Signature	Date

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