



# INTEGRATIVE THERAPIES, INC.

7E Oak Branch Drive • Greensboro • North Carolina • 27407

Phone: 336-294-0910

Fax: 336-218-0294

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*Congratulations! You have taken a step forward on your journey to whole body wellness. You may be seeking nutritional services to minimize symptoms, meet specific dietary needs, manage your weight or make modification toward a more healthy lifestyle. Whatever your goals may be, we are here to guide you.*

*In addition, we are fortunate to be able to offer nutrition counseling and recommendations that are backed by a variety of scientific tests. We are currently offering food and chemical sensitivity testing.. Please inquire at your first visit if you would like more information.*

*To better serve you, we ask that you complete the included 3-day food journal. Please choose 3 days that are representative of “typical” days for you. Completion of the food journal, prior to your first visit, will allow us to spend more time working with you, to develop your nutrition plan when we meet. Please contact us, if you have any questions about the food journal.*

*We look forward to working with you.*

*Melanie Bopp, PhD, RD ,LDN*

*Joyce Eury, RD, LDN*

# INTEGRATIVE THERAPIES

7 E Oak Branch Drive · Greensboro NC 27407 · 336 294-0910

## **Nutrition Journal**

**Name:** \_\_\_\_\_ **Day of the week:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>Time</b>	<b>Food Item</b>	<b>Amount</b>	<b>Mood</b>	<b>Location</b>
Record before and after your meal.	Describe food, including brand names, restaurant names, and method of preparation, such as baked, broiled, and fried. Include all condiments, such as ketchup, mustard, and dressings. Include beverages, such as milk, juice, and regular soda.	Weighing your food is ideal or use common kitchen terms, such as cup, teaspoon, ounces, cans, etc.	Are you happy, sad, angry, or anxious? Are you hungry or content? Are you alone, bored, standing, or sitting?	Where are you when you are eating? Living room, bedroom, kitchen, etc.
<b>Morning</b>				
<b>Morning Snack</b>				
<b>Afternoon</b>				
<b>Afternoon Snack</b>				
<b>Evening</b>				
<b>Late Night Snack</b>				

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# 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-imburement.

#### 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 – 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)**

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**Name (Printed)**

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**Signature**

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**Date**



## 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 \_\_\_\_\_