Integrated Therapy, LLC
ANNA BOGUSLAWSKA, MSPT
BOARD CERTIFIED PHYSICAL THERAPIST

2006 Eastern Suburb, Christiansted, VI 00820
Work: (340) 227-8093
Mobile: (340) 277-7391
Fax: (321) 362-7441
Email: ANNA@INTEGRATEDPTSTX.COM
WWW.INTEGRATEDPTSTX.COM

PATIENT INFORMATION:

Name: _____ DOB: _____ SSN: _____

Mailing Address: _____ City /State / Zip: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____ Approval to contact you at work: ☐ Yes ☐ No

If patient is a minor, please provide guarantor information:

Name: _____ Relation: _____ DOB: _____

Mailing Address: _____ SSN: _____ Phone: _____

EMERGENCY CONTACT:

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PRIVATE INSURANCE INFORMATION:

Primary Insurance Company: _____ Policy#: _____

Address: _____ City / State / Zip _____

Insured's Name: _____ DOB: _____ SSN: _____

Secondary Insurance Company: _____ Policy#: _____

Address: _____ City / State / Zip _____

CANCELLATION POLICY: 24 hours notice is required for all cancellations, or the full appointment fee will be charged.

Signature : _____ Print Name: _____ Date: _____

Who can I speak to about your Therapy? _____

AUTHORIZATION AND RELEASE:
I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payer's and/or other health practitioners. I authorize and request my insurance company to pay directly to the therapist. I understand that my insurance carrier may pay less than the actual bill for services; I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the case of default on payment of this account, I agree to pay collection costs (20% of the unpaid balance due in addition to the unpaid balance due under this agreement) and reasonable attorneys fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signature: _____ Print Name: _____ Date: _____

Signature of Patient / Legal Guardian if Minor