Dear ,

Thank you for choosing **In Touch Therapy**. Your initial evaluation is scheduled for:

Date: _____

Please arrive by: _____ (to allow time for check-in and review of your paperwork).

Please bring the following items:

- A **written list of current medications**, including dose and frequency (we can keep or copy it).
- **Completed and signed paperwork**
- **Driver's license**
- **Insurance cards**
- **Prescription, referral, or doctor's order** (if applicable)
- **X-rays or MRI results** (if available, but not required for your first visit)

Before your visit:

- **Confirm your appointment.**
  We require confirmation of your initial evaluation reservation. Please return our call or leave a message after hours to confirm.
  If we are unable to confirm with you at least **24 hours before your scheduled time**, your appointment will be **cancelled** and offered to another patient.
- **Dress comfortably.**
  Please wear loose-fitting clothing and athletic shoes.

Please read over the **Reservation and Cancellation Policy**, and **Notice of Privacy Practices** before signing the **Consent for Treatment, Assignment of Benefits, and Financial Policies** form.

If you have any questions, please call us at **(434) 447-3322**.
We look forward to working with you and thank you for choosing In Touch Therapy.

Warm regards,

The In Touch Therapy Team

1187 NORTH MECKLENBRUG AVENUE • POST OFFICE BOX 217 • SOUTH HILL, VA 23970
PHONE: (434) 447-3322 • FAX (434) 447-3282
WEBSITE: www.in-touchtherapy.com

In Touch Therapy — Notice of Privacy Practices

Plain-Language Summary

Your privacy matters to us. This notice explains how we may use and share your health information, your rights, and our responsibilities.

How we use your information

We may use or share your information to:
- Treat you and coordinate your care.
- Bill for services and manage payment.
- Run our clinic, improve quality, and meet legal or regulatory requirements.

We may also share information without your permission when required by law—for example, to report suspected abuse, prevent serious threats, comply with public-health reporting, or respond to a court order.

Your rights

You have the right to:
- Get a copy of your records or ask us to correct them.
- Request limits on who sees your information.
- Ask us to contact you in a certain way (for example, by cell or mail).
- Receive a list of certain disclosures we have made.
- Receive a paper or electronic copy of this notice anytime.

Communication and telehealth

We may send appointment reminders or updates by phone or text. If we provide telehealth services, your session will be conducted using HIPAA-compliant technology.

Our responsibilities

We are required by law to protect your information, provide this notice, and follow it. If a privacy breach occurs, we will let you know. We will not sell or share your information for marketing without your written permission.

Questions or concerns?

Contact: Privacy Officer
In Touch Therapy
Phone: 434-447-3322
PO Box 217, South Hill, VA 23970
Website: in-touchtherapy.com

(Effective 2025; replaces prior version from 2006)

Consent for Treatment, Assignment of Benefits and Policies

Consent for Treatment
I authorize In Touch Therapy to provide medical treatment to me or my dependent.

Assignment of Benefits
I request that payment of authorized Medicare or applicable private insurance benefits be paid directly to In Touch Therapy for services provided under their care.

Release of Medical Information
I authorize In Touch Therapy to release necessary medical information to my insurance company, its agents, or any third party payor in order for payable benefits for these services to be determined.

Financial Responsibility
I understand that co-pays are due at the time of service.

I understand that if my plan includes a deductible or coinsurance, partial payment will be collected at each visit to help manage my balance as it accrues.

I understand that In Touch Therapy will file my insurance as a courtesy; however, I am ultimately responsible for full payment of all charges. I further understand that if my account is referred to a collection agency, I will be responsible for collection costs equal to 25% of my balance.

I understand that I should notify the front desk if I anticipate difficulty paying my balance so that a payment plan can be discussed.

Referrals
I understand that if my insurance company requires a referral, I am responsible for obtaining it prior to my visit.

Medicare Patients
I understand that I am responsible for Medicare deductible and co-insurance. If I have a secondary insurance that does not pay the deductible or co-insurance amount, I understand that I will be billed for and agree to pay the remaining amount due.

Returned Checks
I understand that I will be charged $25 for any check that is returned for insufficient funds. Payment for future visits may be required by cash or credit card.

Notice of Privacy Practices
I acknowledge that I have received or been offered a copy of In Touch Therapy's *Notice of Privacy Practices*.

Patient Acknowledgment
I have read the above statements and I understand my responsibilities. A copy of this authorization will be considered as valid as the original.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name

Reservation and Cancellation Policy

At In Touch Therapy, your appointment time is reserved just for you. We want to respect your time and the time of our therapists and other patients.

Arriving on Time

Please arrive **5 minutes before your appointment** to allow for check-in. If you're running late, call us at **(434) 447-3322**. Your therapist will do their best to provide treatment during the time left in your session, but it may be shortened so that the clinic can keep all scheduled appointments on track.

Cancellations and No-Shows

If you need to cancel or reschedule, please **call by 2pm the day before** your appointment so we can offer the time to another patient.

For Monday Appointments: If your appointment is scheduled for a Monday, please call by 12 pm on the preceding Friday to cancel or reschedule. This helps us ensure that the time can be made available to another patient.

- If you miss your appointment or cancel without notice, a **$25 fee** will apply for standard visits or **$75 for an initial evaluation**.

We understand that emergencies can happen unexpectedly. If you are unable to notify us within the required timeframe due to an emergency, please contact our office as soon as possible so we can review your situation on a case-by-case basis.

- Repeated missed appointments or late cancellations may result in loss of future scheduling privileges.

You can cancel by calling **(434) 447-3322** — if we don't answer, please leave a detailed message.

Thank you for helping us keep care accessible and on time for everyone.

Acknowledgment

By signing below, I have read and understand this policy and agree to its terms.

_____ _____

Patient or Guardian Signature Date

_____

Printed Name

Patient Information

Name (First MI Last):	Date of Birth:	Gender:
Mailing Address:	Social Security #:	
Physical Address (if different):	Referring Doctor:	
City:	Marital Status (M, S, D, W):	
State, Zip:	Employer:	
Home Phone:	Emergency Contact and relationship:	
Work Phone:	Emergency Phone:	
Cell Phone:	E-mail Address:	

Reminders

As a courtesy, a text OR call reminder of your reservation can be sent the day before your appointment. To request this free service please choose ONE below.

Please send a TEXT reminder to (__ __ __) __ __ __ - __ __ __ __ Please note: This is an unmonitored number, so no replies will be received.

OR

Please send a CALL reminder to (__ __ __) __ __ __ - __ __ __ __

Confidential Medical History/Evaluation

Name: _____ Date: _____

Is this injury: Work related? Yes ____ No____ Auto Accident? Yes ____ No ____

Date of injury: _____

Chief Complaint(s): _____

Current Symptoms (please cirlce): Pain Numbness Stiffness Weakness Difficulty Walking Balance

Condition: New Acute Chronic

List any/all medications you are currently taking: _____

List any surgeries: _____

Circle any diagnostic services for this injury? X-Ray MRI CT scan EMG NCV Other: _____

Any other care received for this problem: _____

Do you have any of the following?

	Yes	No
Asthma, Bronchitis or Emphysema	☐	☐
Shortness of Breath/Chest Pain	☐	☐
Coronary Heart Disease	☐	☐
Pacemaker	☐	☐
High Blood Pressure	☐	☐
Heart Attack/Surgery	☐	☐
Stroke/TIA	☐	☐
Blood Clot/Emboli	☐	☐
Epilepsy/Seizures	☐	☐
Thyroid Trouble/Goiter	☐	☐
Anemia	☐	☐
Infectious Disease	☐	☐
Diabetes	☐	☐
Cancer or Chemo/Radiation	☐	☐
Arthritis/Swollen Joints	☐	☐
Osteoporosis	☐	☐
Varicose Veins	☐	☐
Gout	☐	☐
Sleeping Difficulties	☐	☐
Emotional/Psychological Problems	☐	☐
Bowel or Bladder Problems	☐	☐
Severe/Frequent Headaches	☐	☐
Vision/Hearing Difficulties	☐	☐
Dizziness or Faintness	☐	☐
Are you pregnant?	☐	☐

Smoking Daily _____ Weekly _____

Alcohol Consumption Daily _____ Weekly _____

Do you have pain when performing the following activities?

	Mild	Moderate	Severe	Unable
Bending	☐	☐	☐	☐
Care for Infirm Family	☐	☐	☐	☐
Carrying Groceries	☐	☐	☐	☐
Sit to Stand	☐	☐	☐	☐
Climb Stairs	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Extended Computer Use	☐	☐	☐	☐
Feeding Self	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Lift Children	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Pet Care	☐	☐	☐	☐
Reading (Concentration)	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Shaving	☐	☐	☐	☐
Sexual Activities	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Sitting (Prolonged)	☐	☐	☐	☐
Standing (Prolonged)	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐

Sports _____

Recreational Activities _____

Exercise Daily _____ Weekly _____

Other Medical Conditions _____

Are you aware of your Diagnosis? YES ____ NO ____

Are you aware of your Prognosis? YES ____ NO ____