IMPACT PHYSICAL THERAPY

Commercial Insurance - For Office Use Only

Date & Time of IE: _____
Treating PT: _____
Staff Initials & Date: _____

Are you a previous patient: ☐ Yes ☐ No
Have you had PT previously in the calendar year: ☐ Yes ☐ No
Is this issue: ☐ Work Related ☐ Auto Accident Related ☐ Other

Patient Information

Last Name:_____ First Name: _____ Middle Initial: ___

Referring/Treating Physician or Healthcare Provider: _____

Dx/Reason for Visit: _____ Date of RX (if applicable): _____

Date of Birth:_____ Gender Listed on Insurance: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____

Home Address:_____ Apt #_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone: _____

E-mail address: _____

Would you like to receive appointment reminders? ☐ Text ☐ E-mail ☐ None

Would you like to receive your billing statement: ☐ Text ☐ E-mail ☐ Paper

May IMPACT Physical Therapy contact you via email for billing purposes? ☐ Yes ☐ No

Employer:_____ Occupation: _____

Spouse Name:_____ Spouse Employer:_____

How were you referred to IMPACT: _____

Insurance Information

Name of Primary Insurance: _____

Policy Holder Name:_____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Group # _____ Policy/ID # _____

Billing Address (for statements to be sent): _____

City: _____ State: _____ Zip: _____

Ins Phone: _____

Name of Secondary Insurance: _____

Policy Holder Name:_____ Relationship to patient: _____

Policy Holder Date of Birth:_____ Group#_____ Policy /ID #_____

IMPACT PHYSICAL THERAPY

Past Medical History

Patient Name: _____ Age: _____ Sex: F____M _____

What is your main complaint and in what area is it located? _____

_____

Occupation:_____Are you presently working? ☐ Yes ☐ No If no - Last Day Worked: _____

Have you ever had these symptoms before? ☐ Yes ☐ No If yes, When? _____
Have you had physical therapy, occupational therapy or chiropractic care for this injury before? ☐ Yes ☐ No

Which one and when? _____

Check all of those which apply to your current condition:

☐ Work Related Injury	☐ Sports Injury	☐ Motor Vehicle
☐ Accident	☐ Aggravation of Pre-Existing Injury	☐ Causes Unknown
☐ Injury Recurrence	☐ Lifting Injury	☐ Fall

What have you been doing to decrease your pain? _____

On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level? _____

Are your symptoms getting worse/ better/ the same/ since your injury? _____

Are you currently taking any medications? (Please list) _____

_____

Are you allergic to any medications? (If yes, please list) _____

_____

Do you have, or have you had any of the following?

○ Diabetes	○ Cancer	○ Metal Implants	○ Headaches	○ Nausea/Vomiting
○ Chest Pain	○ Asthma	○ Dizziness	○ Kidney Problems	○ Ear Ringing
○ Heart Disease	○ Arthritis	○ Fractures	○ Bladder Problems	○ Hypoglycemia
○ Pacemaker	○ Aids/HIV	○ Skin Allergies	○ High Blood Pressure	○ Seizures
○ Allergies to Cold	○ Allergies to Heat		○ Respiratory Problems	○ Deep Vein Thrombosis (DVT)
○ Recent fall(s) within the past year (How many ___)				

Are You Pregnant ☐ Yes ☐ No
If you answered yes to any of the above, please explain and give an approximate date of occurrence: _____

_____

Please check tests you have had performed: ☐ None ☐ X Rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other _____

Check any of the following activities which you have difficulty with due to your injury:

○ Housekeeping	○ Lifting	○ Driving	○ Shopping	○ Reaching
○ Dressing	○ Cooking	○ Climbing Stairs	○ Child Care	○ Bending
○ Yard Work	○ Sit to Stand			

List all of your surgeries/dates: _____

Is there any other information about your present health that we should know about? _____

_____ _____ _____
Date Patient Signature PT Initials

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for IMPACT Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

I acknowledge that I am financially responsible for payment of all services that are not paid by insurance carrier. I understand that all co-payments and self-pay services are due at the time of service. I certify that I was verbally given a statement of a quote of benefits by IMPACT Physical Therapy. The undersigned also agree (s) to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency, in addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court. I expressly consent to be contacted, by IMPACT Physical Therapy or anyone calling on its behalf, for any and all purposes, at any telephone number, or physical or electronic address I provide or which I may be reached, including any wireless telephone number. I agree that IMPACT Physical Therapy may contact me in anyway, including calls or prerecorded or artificial voice or text messages delivered by an automated telephone dialing system, or email address delivered by an automatic emailing system. I acknowledge that this consent cannot be revoked without prior agreement and acceptance by IMPACT Physical Therapy. I agree to promptly notify IMPACT Physical Therapy at any time my contact information changes.

RELEASE OF INFORMATION

I hereby authorize IMPACT Physical Therapy, LLC to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past. I also authorize IMPACT Physical Therapy, LLC practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at any time. By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

CANCELLATION AND NO-SHOW POLICY

If you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance. We will make every attempt to reschedule your appointment. If you miss your appointment without calling in advance or cancel within 24 hours, you will be charged a $25.00 cancellation fee. This payment takes effect on your second missed appointment without previous notice. Case managers and referring physicians for worker's compensation patients are notified after each missed appointment.

HIPAA PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice. I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at any time.

In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account. (Optional)

_____	_____	_____
Name/Relationship	**Name/Relationship**	**Name/Relationship**
_____	_____	_____
Contact Number	**Contact Number**	**Contact Number**

_____

Patient/Guardian Name (Print)

_____	_____	_____
Patient/Guardian Signature	Date	Staff Initials & Date