NEW PATIENT INFORMATION

PERSONAL INFORMATION:

Name: ______________________________ Date of Birth: ____________________

Address: ____

City: ______________________________ State: ______________ Zip: ______________

SSN: ____________(Last 4 digits only) Sex: ________ Marital Status: ____________________

Phone: (home) ____________________________ cell: ____________________________

Emergency Contact: ____________________________ Emergency contact number: ______________

Referring Physician: ____

HISTORY:

Do you have a pacemaker? ____________ Allergies: ______________________________

Medications currently using: ____

Previous surgeries: ____

Previous diagnoses/medications: ____

Workers Compensation? __________ **Date of Injury:** ______________________________

INSURANCE:

Insured Name: ______________________________ DOB: ______________________________

Primary Insurance: ______________________________ Secondary Insurance: ____________________

I, ______________________________, hereby authorize and instruct my insurance carrier to pay Impact Therapy, Inc., directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all co-pays, deductibles, and balances not covered by Medicare, or my insurance carrier, provided my specific plan does normally pay for the services and/or products referred to me by the medical providers at this facility. I understand that if I default on my account it may be sent to collections, which will result in an additional fee. If I am the legal guardian/representative of the patient named above, I accept responsibility for the above as well. I also authorize the release of any and all medical records to my insurance carrier for the purpose of expediting claim payment.

______________________________ ______________________________

Insured or Authorized Person's Signature Date

PAYMENT POLICIES:

All charges that you incur at our office are your responsibility. You may pay for your charges at each visit or choose to use our insurance filing service. On your first visit, you will be required to pay any unmet deductible and co-pay. You will be responsible for your co-pay each visit unless other arrangements have been made. We understand that some deductible can be high, and we will be glad to set up payment arrangements with you.

Your insurance company must allow you to have reimbursement payment sent directly to us. If your insurance does not allow this, we require that you pay for all treatment at the time of services rendered.

We will bill your insurance company daily and use all efforts to collect payment. However, any charges that remain unpaid for 60 days will become your responsibility.

To prevent patients from waiting for treatment, we do not overbook appointments. Please give a 24 hour notice when cancelling appointments.

I have read and understand the policies of Impact Therapy Inc. I hereby authorize Impact Therapy Inc to apply benefits on my behalf of the covered services rendered at the office. I request that payment from my insurance company be made directly to Impact Therapy or to the party who accepts assignments. I certify the information I have reported is correct. I understand that I am responsible for any amount not covered by insurance. I agree to pay all costs of collection, including a reasonable attorney's fee, should this account be turned over to collections.

______________________________ ________________________

Signature Date

Worker's Compensation Patients Only

Physical Therapy is being provided to me as prescribed treatment for work-related injury. I authorize Impact Therapy to furnish information to my employer and/or worker's compensation carrier concerning my injury and treatment.

I understand Impact Therapy is responsible for notifying my adjuster, case manager, and doctor if I fail to meet my prescribed number of treatments each week, I understand my attendance is mandatory unless excused by my case manager, doctor, or therapist. If is my responsibility to be on time and give my best effort.

______________________________ ________________________

Signature Date

Patient Information Consent Form

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Impact Therapy, Inc. The physical therapist will explain the nature and purpose of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complication, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to Impact Therapy, Inc for services rendered. Impact Therapy, Inc will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Patient Information Consent Form (HIPPA)

I have read and fully understand Impact Therapy, Inc.'s Notice of Information Practices. I understand that Impact Therapy, Inc. may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and 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 Impact Therapy, Inc. will consider requests for restrictions on a case by case basis, but is not required to oblige such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Impact Therapy, Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Impact Therapy, Inc. has 30 days to respond to my request.

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 of 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 non, please print "none" below.

Authorized Designees:

Name:______________________________ Relationship: ____________________

Name:______________________________ Relationship: ____________________

Name:______________________________ Relationship: ____________________

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above. I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Impact Therapy, Inc. In addition, I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and health care operations.

Patient Signature: ______________________________ Date: ____________________

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