Phone: 307-444-4466
Fax: 307-444-4468

Impact Physical Therapy
96 Yellow Creek Rd.
Evanston, WY. 82930

PATIENT INFORMATION

Patient name:_____ Today's date:_____

Address:_____
Street City State Zip

Phone:_____Cell: _____E-mail:_____
☐ Please check if you would like text message reminders.

Date of birth_____ Age___ ___Male___Female

Occupation:_____

Billing party:_____Relationship: (circle one): self, spouse, auto, employer

Primary Care Physician _____

Emergency contact person:_____ Phone:_____

Only complete if Workman's Comp case:
*Employer:*_____ *Phone:*_____

*Address:*_____
Street *City* *State* *Zip*

*Workman's Comp claim number:*_____

Only complete if copy is not provided:
Primary insurance:_____

Policy holder's name and date of birth_____

Secondary Insurance:_____

Policy holder's name and date of birth_____

Patient/Guardian Signature: _____ Date_____

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PATIENT MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____

Weight: _____ Height: _____ If female, are you pregnant? _____ Falls in the last year? _____

Have you ever been diagnosed with any of the following?

Heart Conditions	☐ No	☐ Yes_____	Osteoarthritis	☐ No	☐ Yes_____
Hypertension	☐ No	☐ Yes_____	Rheumatoid arthritis	☐ No	☐ Yes_____
Stroke	☐ No	☐ Yes_____	Asthma	☐ No	☐ Yes_____
Heart attack	☐ No	☐ Yes_____	Respiratory problems	☐ No	☐ Yes_____
Pacemaker	☐ No	☐ Yes_____	HIV	☐ No	☐ Yes_____
Seizures	☐ No	☐ Yes_____	Hepatitis	☐ No	☐ Yes_____
Depression	☐ No	☐ Yes_____	Thyroid problems	☐ No	☐ Yes_____
Osteoporosis	☐ No	☐ Yes_____	Bowel/bladder problems	☐ No	☐ Yes_____
Diabetes	☐ No	☐ Yes_____	Tuberculosis	☐ No	☐ Yes_____
Cancer	☐ No	☐ Yes_____	Autoimmune disease	☐ No	☐ Yes_____

Please list surgery type and date:_____

_____

_____

Is there any other information regarding your past medical history that we should know about?_____

_____

_____

Current medication list: _____

_____

_____

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CURRENT PROBLEMS

Describe current complaint and when it started?_____

_____

Since onset are symptoms: Better ☐ Worse ☐ Same ☐

What makes it better?_____ What makes it worse?_____

Have you received any other treatment for this problem? _____

Circle if applicable: MRI / x-ray / other

Please circle the appropriate number that best describes your pain level

Pain Scale: 0-10 0 = No Pain 10 = Severe Pain

Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

Please indicate where your symptoms are located and symptom type:

XXX: dull/ ache

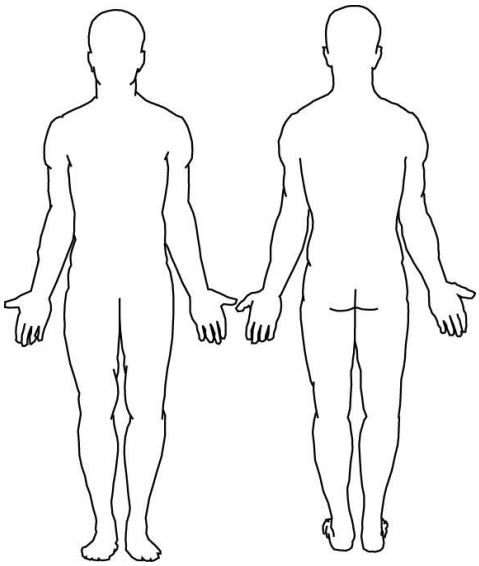
///: sharp

000: numbness

^^^: pins and needles

###: burning

FRONT BACK



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POLICIES REGARDING CARE, FEES, AND BILLS

Thank you for choosing Impact Physical Therapy as your physical therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy. Please read and sign prior to your treatment.

Payment of services are due prior to or upon completion of each treatment visit. We accept cash, MasterCard, Visa, Discover, American Express or personal checks. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

CARE: Our fee schedule is well within the MEDICARE guidelines for reasonable and customary charges for our region. A normal therapy session could average around $180.00 per visit. The charge per visit could be lower or higher depending on the length of the session and the type of treatment provided.

FINANCIAL RESPONSIBILITY: You are ultimately responsible for the financial resolution of your bill. You are financially responsible for any and all charges you incur that are not covered by your insurance or Workers' Compensation.

- In the case that your Workers' Compensation claim is not accepted by your Work Comp carrier, and they refuse to pay, you will be responsible for payment in full.
- It is especially important to know that in a liability situation, including but not limited to auto accidents, it is your responsibility to make sure we are paid for the treatment you receive. If a settlement is expected at the end of your treatment, and you have no other insurance, we will expect a minimum monthly good faith payment.
- If your bill is not paid within the allotted amount of time it will be turned over to a third-party collection service. In the event any amount(s) is/are referred to a third party debt collection agency, I agree to pay additional interest, court costs and responsible attorney's fees. I will also be responsible for collection fee of up to 33.3% of the principal amount(s) owing.

MISSED APPOINTMENTS: Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrivals of greater than 15 minutes may result in a shortened treatment or cancellation. It is our policy to reschedule any cancelled appointment to the same week at the time of your call. **There is a $25 charge for no-shows or cancellations without a 24 hour notice.** Attending your scheduled appointment is crucial to successful treatment and recovery of your injury.

Signature of Responsible Party:_____ Date: _____

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NOTICE OF PRIVACY PRACTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. A copy of the Notice of Privacy Practices is availibe in the front waiting area and a hard copy may be obtained upon request. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Impact Physical Therapy will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I give Impact Physical Therapy permission to disclose and discuss any information related to my medical conditions with the following individuals:

Name: _____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check all the apply)

Home Phone or Cell Phone

☐ OK to leave message with detailed information
☐ Leave message with call-back number only
☐ OK to leave message with family members or other persons living in the same household

Work Phone

☐ OK to leave message with detailed information
☐ Leave message with call-back number only
☐ OK to leave message with secretary, assistant, or other individual who regularly answers the phone

Patient/Guardian Signature:_____ Date:_____