Impact Rehabilitation & Sports Medicine, Inc.

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Date_____Soc.Sec#_____Birthdate_____

Last Name_____First _____Middle Initial_____

Address_____Home#_____Cell#_____

City_____State_____Zip Code_____

Male___ Female____

Single_____ Married_____Divorced_____Minor____

Employer_____Business Phone_____

Business Address_____Occupation_____

Emergency Contact_____Phone #_____

PRIMARY INSURANCE

Person Responsible for Account_____

Relationship to Patient_____Birthdate_____Soc.Sec_____

Address_____Home Phone_____

City_____State_____Zip Code_____

Responsible Party Employeed By_____Business Phone_____

Business Address_____Occupation_____

Insurance Company_____

Insurance Address_____

Contract or I.D. Number_____Group Number_____

ADDITIONAL INSURANCE

Insured First Name_____Last_____Intitial_____

Relationship to Patient_____Birthdate_____Soc.Sec_____

Address_____Home Phone_____

City_____State_____Zip Code_____

Insured Employed By_____Business Phone_____

Insurance Company_____

Insurance Address_____

Contract or I.D. Number_____Group Number_____

WORKER'S COMPENSATION

Insurance Name_____Date of Injury_____

Address_____City_____State____Zip _____

Employer_____Phone number _____

Address_____City_____State____Zip_____

Adjuster_____Case Manager_____

Adjuster Phone_____Case Manager Phone_____

Adjuster Fax_____Case Manger Fax_____

Claim Number_____

Assignment of Benefits/Authorization to Release Medical Information/Consent to Treat

I hereby assign all medical benefits to which I am entitled to Impact Rehabilitation in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principle amount owing as well as all reasonable costs associated with the collection of debt. This includes but is not limited to collection of service fees, attorney fees, and all court cost and additional legal fees associated with the recovery of debt. I hereby authorize said assignee to release all information necessary to secure payments of benefits. A copy of this assignment shall be considered as effective and valid as the original. I do herby consent to such treatment by the authorized personnel of Impact Rehabilitation as may be dictated by prudent medical by my illness, injury, or condition. This consent is intended as a waiver or liability for such treatment excepting acts of negligence.

Signature_____Date_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures of your Health Information

Treatment:
Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment:
Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request information on dates of services, the services provided, and the medical condition being treated.

Health care operations:
Your health information may be used as necessary to support the day-to-day activities and management of Impact Rehabilitation. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality.

Law enforcement:
Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting:
Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information:
Appointment reminders. Your health information will be used by our staff to send appointment reminders.

Information about treatments:
Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Name: _____

*HIPPA Acknowledgement/Consent

I hereby acknowledge that I have received a copy of The Notice of Privacy Practice for Impact Rehabilitation and Sports Medicine, INC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations.

_____ _____

Signature of Patient or Authorized Representative Date

If representative, print name and relationship.

_____

Health History Questionnaire

Name_____Age_____Occupation_____

Please check if you are experiencing or have any of the following:

_____Heart Disease

_____Chest Pain

_____Stroke

_____High Blood Pressure

_____Anemia

_____Diabetes

_____Lung Disease or SOB

_____Bronchitis

_____Emphysema

_____Circulation Problems

_____HIV-AIDS

_____Cancer

_____Arthritis

_____Kidney Disease

_____Hiatal Hernia

_____Fractures

_____Dizziness/Fainting

_____Seizures

_____Asthma

_____Currently Pregnant

_____Poor Appetite

_____High Cholesterol

List any other conditions that are not listed above_____
_____

Please list any problems that may be aggravated by exercise_____
_____

Please list any surgeries, injuries or other conditions for which you have been treated___
_____

Do you take any medications?_____Yes_____No Please list all current medications ___
_____
_____

Do you have any allergies?_____Yes_____No Please list all allergies _____

When did your condition begin?_____