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

Social Security Number: ___________________Phone:_________________Cell: ______________

__Married __Single__Other Date of birth_________________ Age___ ___Male___Female

Responsible party:______________________________ Relationship:_________________________

Emergency contact person:____________________________ Phone:_________________________

Employer:____ Phone:_________________________

Address:____
Street City State Zip

Employer contact name (If applicable):____

Please circle one insurance type: WORKCOMP AUTO PRIVATE SELF-PAY

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?

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

If you marked yes to any of these please explain:____

____

Please list any other surgeries you have had including type and date:____________________________

____

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

____

Please list any current medications: ____

____

____

Patient/Guardian Signature: ___________________________________ Date:___________________

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CURRENT PROBLEMS

What brings you to Impact Physical Therapy today? ____

Are your symptoms: ☐ Better ☐ Worse ☐ Same

What makes it better?____________________ What makes it worse?______________________

Have you received any other treatment for this problem? ______________________________________

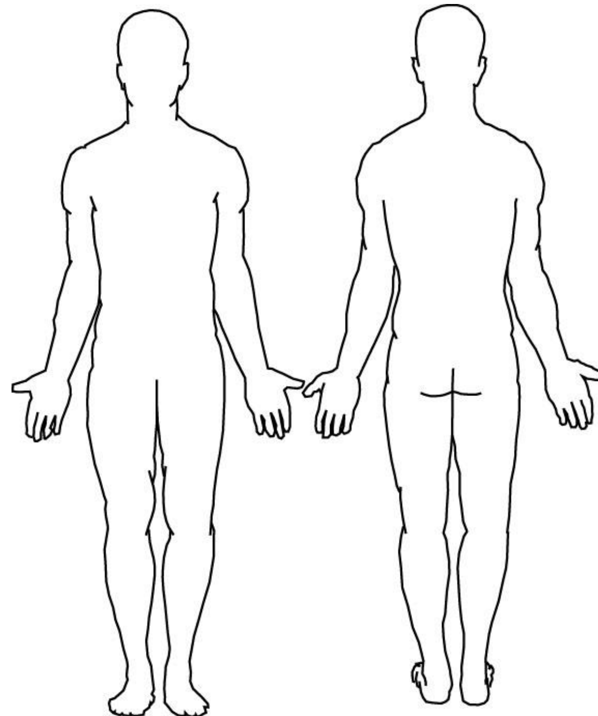
When did your symptoms start?____________________ MRI/X-Ray?________________________

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 below where your symptoms are located



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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.

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

Email (Please specify email address) ______________________________________
☐ OK to leave message for appointment reminders and home exercise program

Patient/Guardian Signature:_____________________________ Date:_________________