IMPACT PHYSICAL THERAPY

Locally Owned and Run by a Physical Therapist

Patient Information

Last Name	First Name (legal/ ins name)	MI	Alias/Nickname	DOB	☐ Male (he/him) ☐ Female (she/her) ☐ Other*(they/them)

Home Address	City	State	Zip

Primary phone #	☐ Home ☐ Cell ☐ Work	Secondary Telephone #	☐ Home ☐ Cell ☐ Work	**Relationship Status** ☐ Single ☐ Married ☐ Other

Employment Status ☐ Employed ☐ Retired ☐ Student ☐ N/A	SS#	Email Address	*Ok to send personal account/health information?*

Employer/ School Name	Position/Title	Phone/Text : ☐ Yes ☐ No	Email: ☐ Yes ☐ No

Referring Physician Information

Last Name	First Name	City or Clinic Name	Telephone

Emergency Contact or Legal Guardian Information

Last Name	First Name	Primary Phone#	Secondary Phone#	Relationship to patient: ☐ Spouse ☐ Parent/Guardian ☐ Other

Email

Injury Information

Was this injury in result to the following: ☐ Job☐ Overuse ☐ Auto ☐ Ongoing ☐Home ☐ Other (Please Explain) _____	Please indicate injury date _____/_____/_____or Ongoing ☐	How will your injury be billed ☐ Private Health Insurance – please provide copy ☐ Labor and Industries/ Workers Compensation ☐ Auto- we **do not** accept third party and/or lien (lawsuits) ☐ Self-Pay- $120.00 will be due at time of service

Private Healthcare Insurance Information- *If this is auto or labor and industries skip to section*

☐ Copy Provided to Front office (just write insurance company and skip remaining)

Primary Insurance Company	Identification #	Group Number	Claims Telephone #
Secondary Insurance Company	Identification #	Group Number	Claims Telephone #

Auto/PIP, Labor and Industries & Worker's Compensation- *please see our tracking logs and verification forms*

Company Name	Claim Number	Claims Adjuster Name	Claims Adjuster Phone#

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Impact Physical Therapy's Payment and Policy Procedures

Responsible Party Statement /Assignment of Benefits Authorization

As responsible party, I agree that all charges that are not directly paid by my insurance company, Labor and Industries, Worker's Compensation or Auto/PIP will be my responsibility. I hereby assign all medical benefits to which I am entitled to Impact Physical Therapy in the event they file insurance on my behalf. I understand my insurance may require my medical records to be forwarded for processing of any and all claims. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Impact Physical Therapy as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Responsible Party	Date
X	

Impact Physical Therapy Payment Policy/Consent to Treatment

I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment; I accept responsibility for the principal amount owing as well as reasonable costs associated with the collection of the debt. This includes but is not limited to collection service fees, attorney fees, and all court costs and additional legal fees associated with the recovery of this debt. At Impact Physical Therapy we strive to provide outstanding physical therapy services along with the best customer service possible. To continue our rewarding care of our patients we must make sure we are getting reimbursed in a timely manner. We take every effort to make sure your experience with insurance goes as smoothly as possible. We bill your insurance company as a courtesy and follow-up on claims. In the event your insurance does not pay in a timely manner we will notify you and will be transferred to patient responsibility. At that time our payment procedures will be as follows;

*Any and all copays paid late will have a $5 late charge added (If you are able to call the same evening and pay over the phone this will not apply)

*Any patient balance not paid within 30 days will be charged a late fee of 1.5%. This fee will be compounded monthly until the final bill has been paid.

Responsible Party	Date
X	

Late Cancel/No Show Policy

Impact Physical Therapy strives to provide all of our patients with the best possible care. In order to provide this care, it is essential that you keep all scheduled appointments. In order to do this, we are requesting that you provide us with 24-hour cancellation notice. Failure to provide this notice prevents us from helping other patients during the time that you did not use. Therefore, failure to provide us with adequate notice will result in a charge of $120. This missed appointment fee is not covered by your insurance plan and will be billed to you directly. If you are continuing treatment please be prepared to pay this fee at your following appointment. We do understand things come-up that are out of our control and we can consider these circumstances. Please note this will only be considered once due to not only the harm it causes our office and other patients who also need affordable services, but continued lapse in treatment may be affect your recovery. We trust you respect and understand our position and will promptly fulfill your financial obligations to our office.

For our Labor and Industries/ Worker's Compensation patients, by law we are required to report any missed visits to your claims representative. Please realize that your physical therapy is your responsibility and we take you care very seriously. Failure to attend your scheduled visits may jeopardize your status with your insurance plan. Labor and Industry/ Worker's Compensation patients will be personally charged the fee of $120 which will not be paid by Labor and Industries/ Worker's Compensation benefits. If you have questions regarding this, please refer to the following web address: http://apps. Leg.wa.gov/WAC/default.aspx?cite=296-20-010.

**In some cases, continued no-shows and/or late cancellations your referring physician may be contacted and your treatment may be placed on hold until you are able to fully commit to your treatment plan to move forward in recovery.*

Please call and re-schedule any visit in which you know you cannot make in advance.
We thank you for your consideration.

I have read Impact Physical Therapy's cancellation policy.

Responsible Party	Date
X	

Impact Physical Therapy Privacy Practices-HIPAA

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED ANDHOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Impact Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and the following information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Impact Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide.

Impact Physical Therapy may also use or disclose your health information without prior authorization for public health purpose, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, Impact Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Impact Physical Therapy may change its policy at any time. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

CONCERNS AND COMPLAINTS

If you are concerned that Impact Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact us HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Impact Physical Therapy's health information practices, or if you have a complaint, please contact the following office:

HIPPAA Compliance Office
Impact Physical Therapy
4300 198th St SW Lynnwood
Lynnwood, Washington 98036
#425-778-2325

I have read and fully understand Impact Physical Therapy's notice of Information Practices. I understand that Impact Physical Therapy may use or disclose my personal health information for the purposes of carrying our treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. 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 company in writing. I also understand that Impact Physical Therapy will consider requests for restriction on case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Impact Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the company in writing at any time.

_____	_____	_____
Patient Printed Name	Patient Signature	Date