

**Impact Physical Therapy
Notice of Patient Information Practices**

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

Impact Physical Therapy LEGAL DUTY

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. For example, Impact Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

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

In any other situation, Impact Physical Therapys' 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. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. 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 you personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information, treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Impact Physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

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 you personal health information, please contact our 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
6101 200th Street SW Suite 208
Lynnwood, WA 98036
#425-778-2325**

EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM

Dear Patient:

Impact Physical Therapy strives to provide all 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 a 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 \$75.00. This missed appointment fee is not covered by your insurance plan and will be billed to you directly.

I have read Impact Physical Therapy's cancellation policy.

Patient Name : _____ Date: _____

Labor and Industry Patients

By law we are required to report any missed visit to your claims representative. Please realize that your physical therapy is your responsibility and we take your care very seriously. Failure to attend your scheduled visits may jeopardize your status with your insurance plan.

Medicare Patients

All Medicare Patients are required to see their referring Doctor within 60 days of their first Physical Therapy visit and every 30 days thereafter. A new prescription for Physical Therapy must be written by the Doctor on each visit and given to the treating Physical Therapist. IF we do not have an updated prescription from your Doctor, we cannot legally treat you.

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 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 out 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 a 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

REQUEST SIGNATURE FROM EVERY PATIENT

Impact Physical Therapy

PATIENT INFORMATION

LAST NAME		FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	<input type="checkbox"/>	MALE
						<input type="checkbox"/>	FEMALE
HOME ADDRESS			CITY	STATE	ZIP CODE	HOME PHONE	
MARITAL STATUS							
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER							
EMPLOYMENT STATUS				EMPLOYER NAME/SCHOOL NAME		TITLE/POSITION	
<input type="checkbox"/> EMPLOYED <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> PART TIME STUDENT <input type="checkbox"/> N/A							
WORK ADDRESS			CITY	STATE	ZIP CODE	WORK PHONE	
E-MAIL ADDRESS							

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE

Date you were last seen by your referring physician _____

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST	MI		
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE		WORK PHONE		
RELATIONSHIP		PARENT OR GUARDIAN E-MAIL ADDRESS		
<input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> GUARDIAN				

REASON FOR TODAY'S VISIT

IS THIS INJURY/CONDITION RELATED TO YOUR ...			
JOB	CAR	HOME	OTHER ACCIDENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE INDICATE THE DATE OF ACCIDENT OR INJURY		PLEASE INDICATE THE DATE OF ILLNESS (1 ST SYMPTOM)	
PLEASE PROVIDE NAME OF INSURANCE ADJUSTER OR CONTACT			TELEPHONE
PLEASE DESCRIBE INJURY/ACCIDENT/ILLNESS:			

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY, LABOR AND INDUSTRY OR MOTOR VEHICLE INSURANCE, WILL BE MY RESPONSIBILITY.	
RESPONSIBLE PARTY SIGNATURE	DATE
X	

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME		IDENTIFICATION NUMBER OR CLAIM #		GROUP NUMBER
ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE
POLICYHOLDER (if other than patient)		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH
SOCIAL SECURITY NUMBER (of policyholder)		TELEPHONE (of policyholder)	RELATIONSHIP TO PATIENT	
EMPLOYER (of policyholder)				

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME		IDENTIFICATION NUMBER OR CLAIM #		GROUP NUMBER
ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE
POLICYHOLDER (if other than patient)		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH
SOCIAL SECURITY NUMBER (of policyholder)		TELEPHONE (of policyholder)	RELATIONSHIP TO PATIENT	
EMPLOYER (of policyholder)				

For Labor and Industries patients only:

Case manager's name _____

Case manager's phone number _____

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

<p>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 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'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1% PER MONTH (12% ANNUALLY) FOR UNPAID BALANCES OVER THIRTY DAYS OLD. 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.</p>	
AUTHORIZED SIGNATURE X	DATE

IMPACT PHYSICAL THERAPY

PATIENT HISTORY

Name _____ Male _____ Female _____ Date _____
Age _____ Height _____ Weight _____ Occupation _____

CHIEF COMPLAINT AND PRESENT ILLNESS:

Area of injury/symptoms _____ Date your symptoms/injury started _____

How did your symptoms start? _____

Diagnosis from your doctor _____ Date of your next doctor recheck _____

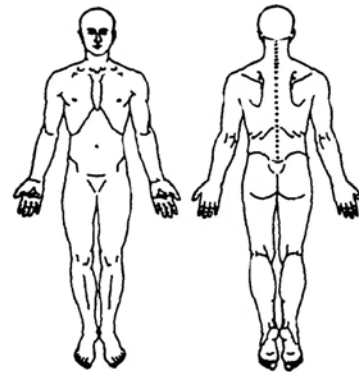
Are you currently off work because of this problem _____ no _____ yes; if yes, last day worked _____

Using the diagram, circle the specific area of pain. If pain travels, draw arrows.

Please RATE your pain level. No pain 1 2 3 4 5 6 7 8 9 10 Worst pain.

How would you DESCRIBE your pain?

dull ache _____ burning _____ heavy _____ sore
deep ache _____ throbbing _____ twinge _____ other
stabbing _____ squeezing _____ cramp
nagging _____ drawing _____ sharp



Are your symptoms intermittent or constant? (circle one)

Do you have any numbness/tingling? _____ Where? _____

Prior to this onset, were you free of these symptoms? Yes _____ No _____ Explain _____

What eases the pain?

What aggravates the pain?

Have you had any other treatment for this problem? _____ What? Chiropractic _____ Physical Therapy _____ Other _____

Did it help?

Do you feel you are getting better, getting worse or staying the same? (circle one)

Have you had x-rays? yes _____ no _____ Findings? _____

Have you had an MRI? yes _____ no _____ Findings? _____

Please list any other tests you have received:

Women only: Are you pregnant? yes _____ no _____ Which trimester? 1 _____ 2 _____ 3 _____

Any other concerns or health changes since the start of this injury/illness?

ACTIVITIES OF DAILY LIVING: Circle activities that are difficult for you and then check the appropriate box.

	no difficulty	with difficulty/pain	cannot perform
Personal hygiene: hair, bathing, toilet			
Dressing: zippers/buttons, upper body, lower body, shoes			
Household chores: reach overhead, lifting/carrying, dust vacuuming, mopping, Meal Preparation: use stove, do dishes			
Yard/Garden: mowing, tilling, weeding, raking, watering			
Walking: stairs, curbs, incline, decline, uneven ground, distances Transportation: Drive self, ride with others, bus, taxi, shopping			

LIST YOUR LEISURE ACTIVITIES (circle those affected by your current problem):

GENERAL MEDICAL:

Have you **EVER** been diagnosed as having any of the following conditions?:

A. Cancer	YES	K. Other arthritic problems	YES
If YES, describe what kind: _____		L. Depression	YES
B. Heart problems	YES	M. Hepatitis	YES
C. High blood pressure	YES	N. Tuberculosis	YES
D. Asthma	YES	O. Stroke	YES
E. Emphysema	YES	P. Kidney disease	YES
F. Chemical dependency (i.e. alcoholism)	YES	Q. Anemia	YES
G. Thyroid problems	YES	R. Epilepsy	YES
H. Diabetes	YES	S. Insomnia	YES
I. Multiple Sclerosis	YES	T. Constipation/diarrhea	YES
J. Rheumatoid arthritis	YES	U. Other:	

If you have been seen by any health care provider during the past 3 months for reasons other than what brought you here, please describe for what reason:

Please list any **SURGERIES** you have had or any **INJURIES** for which you have have been treated (please include approximate dates):

Please list **ALL PRESCRIPTION** and/or **OVER-THE-COUNTER** medications you are currently taking for this and any other condition (including pills, injections, and/or skin patches):

GOALS: Please list your personal goals for therapy:

Patient/Parent/Guardian Signature

Therapist Signature