REGISTRATION FORM

Today's date:	Referring Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Social Security no.:	Responsible party E-mail address: ***(you will receive your statement at this email address)***	Birth date: / /	Age:	Sex: ❑ M ❑ F

If patient is a student, please give parent(s) Cell phone number: ( )❑Mom ❑Dad ❑Other (name)	Home phone number: ( )	Patient's Cell number: ( )

Mailing Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Contact Number: ( )

INSURANCE INFORMATION (PLEASE COMPLETE ALL SECTIONS)

Is this patient covered by insurance? ❑ Yes ❑ No

NAME OF PRIMARY INSURANCE:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy number:	Group #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

NAME OF SECONDARY INSURANCE:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy number:	Group #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

FINANCIAL AGREEMENT

Person responsible for bill:	Birth date: / /	Address (if different):	Responsible party contact #: ( )
Name of Employer:	Occupation:	Responsible party Email Address: ***You will receive your statement at this email address***	Employer phone no.: ( )

The above information is current, accurate and true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Pro Impact Physical Therapy & Sports. It is MY RESPONSIBILITY to keep my insurance active and accurate throughout my plan of care. I understand that I am financially responsible for any balance. I also authorize Pro Impact Physical Therapy or insurance company to release any information required to process my claims.

I further understand that I will receive my statements via email.

Patient/Guardian signature ***Date***

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:	Date of Injury/Onset:
Are you **currently** receiving any other care for the condition mentioned above? ☐ No ☐ Yes- If Yes, please list:	
Have you received therapy services for **other problems/conditions during the current year?** ☐ No ☐ Yes- If Yes, please list:	
Could you be or are you pregnant? ☐ No ☐ Yes	Do you have a pacemaker? ☐ No ☐ Yes

PATIENT AUTHORIZATION

RELEASE OF INFORMATION & CONSENT FOR TREATMENT - All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at this Pro Impact Physical Therapy & Sports Medicine clinic. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Pro Impact Physical Therapy & Sports Performance and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Pro Impact Physical Therapy & Sports Performance and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

I consent for medical photographs to be made of me (or my child or person for whom I am a legal guardian). I understand that the information may be used in my medical record. By consenting to these medical photographs I understand that I will not receive payment from any party (Pro Impact nor patient). Refusal to consent to photographs will in no way affect the medical care I will receive. The signature below certifies that I have read and understand the above information. ______________

Initial:

ASSIGNMENT OF BENEFITS

I authorize payment directly to Pro Impact Physical Therapy & Sports Performance, its subsidiaries and/or affiliates for services and to bill and release payment directly to Pro Impact Physical Therapy & Sports Performance, its subsidiaries and/or affiliates for any physical therapy, occupational therapy, speech-language pathology, rehabilitation, orthotic or prosthetic services provided.

This is a direct assignment of my rights assistive device benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. **Initial:** ______________

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Pro Impact Physical Therapy & Sports Performance, its subsidiaries and /or affiliates.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operation. **Initial:**______________

Patient or Guardian Signature:	Date:

Patient Authorization

Patient Name:	Date of Birth:
PAYMENT GUARANTEE	

I agree to pay Pro Impact Physical Therapy & Sports Performance, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or an insurance contract prohibit payment for these services I will cooperate and assist in the provision of information and authorizations, released, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

Pro Impact files your insurance as a courtesy but you are still financially responsible. The Eligibility and Benefit form provided by ***some*** insurance companies is only an explanation of coverage. This is not a guarantee of payment by the insurance company. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, **I will be responsible for payment of all services**.

If arbitrary determination of a participating insurance company indicates that a treatment or procedure is not medically necessary, the patient or patient's guarantor will be responsible for the remaining balance. **However, it is ultimately the responsibility of the patient or patient's guarantor to know and understand their benefits prior to starting physical therapy.**

FINANCIAL AGREEMENT: I fully understand that I am responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for court costs, attorney fees, and collection fees of up to 33% of the amount due, incurred in the collection of any balance due. I give permission to Pro Impact and any of Pro Impact's vendors, which include collection agencies, attorneys and billers, to contact me on the cell phone numbers I have provided on matters related to my account. I understand that an automated dialer may be used to contact me by these parties and agree to allow them to do so.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Pro Impact Physical Therapy & Sports Performance and/or its affiliates or subsidiaries.

I understand that three statements will be generated in the course of an outstanding balance. After which, a final notice prior to collections will be mailed. Payment in full is expected on outstanding balances. If a payment plan is absolutely necessary, the terms and conditions will be determined by Pro Impact Physical Therapy and Sports Performance owner, not upon the financial plan determined by the client. I further understand and agree that, in addition to all amounts owed for services, which I will be responsible for all costs of collection including, but not limited to, attorney's fees, court cost, filing fees, and any other costs associated with or related to collection efforts instituted by Pro Impact Physical Therapy.

I further acknowledge that Pro Impact sends monthly statements via email and this is how I will receive my statement unless other arrangements are made at the time of my service.

Initial: ______________

Patient or Guardian Signature:	Date:

PRIOR EXPRESS CONSENT

I, ___________________, "Consumer" understands that it is important for Pro Impact Physical Therapy "Service Provider" or an Authorized Entity (as defined below) to be able to communicate with me and have current information about me, my address, my phone number(s), and any other information about me that may assist Service Provider or an Authorized Entity in locating me or communicating with me. In consideration of Service Provider or Authorized Entity providing me services and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, Consumer expressly consents and agrees to the terms and conditions contained in this Prior Express Consent Form.

Authorized Entities: The term "Authorized Entities" shall mean the above referenced Service Provider and any related or affiliated health care provider, physician, service provider, independent contractor (including but not limited to billing services) and each of their respective successors, assigns, agents, attorneys, insurers, representatives, employees, officers, shareholders, partners, parents, subsidiaries, affiliated entities, and all agents and representatives of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of the previously listed persons/entities, including any collection agency or debt collector retained or hired by any of the previously listed persons/entities, and all corporations, persons, or entities in privity with any of them. The term Authorized Entities shall also include any person or entity conducting business or providing services relating to health care at the same physical location at which the Service Provider or any of the previously listed persons/entities conducts some or all of its business, and any person or entity Consumer is referred to by Service Provider, and any person or entity who provides health care services related to the services provided by Service Provider.

Communication Consent: I understand that the purpose of this agreement is to authorize the delivery of calls to me, including, but not limited to, using an automatic telephone dialing system or an artificial or prerecorded voice, or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call (hereinafter "Authorized Communications"). I also understand that my agreement to the terms of this Prior Express Consent Form is not a condition of any Authorized Entity's willingness to provide services to me. To the extent permitted by applicable law, and without limiting any other rights the Authorized Entities may have, I expressly consent and authorize the Authorized Entities to communicate with me for any reason, including reasons related to the services provided by Authorized Entities or services to be provided in the future by the Authorized Entities, including collection of amounts owed for said services, via Authorized Communications at the telephone number or numbers I provide below, or that is provided on my behalf, or any phone number that any Authorized Entity obtains or finds on its own which is not provided by me. In addition, I further expressly consent and authorize the Authorized Entities to communicate with me via SMS text messages, other forms of electronic messages, electronic mail, or other electronic communication sent or directed to me through any medium, no matter how the Authorized Entity obtain such contact information. Any Authorized Entity may communicate with me using any current or future means of communication, even if those means are not now known to the Authorized Entity or Consumer. I authorize any and all of the communication methods described in this paragraph even if I will incur a fee or a cost to receive such communications. I further promise to immediately notify the Authorized Entity if any telephone number or email address or other unique electronic identifier or mode of communication that I provided to any Authorized Entity changes or is no longer used by me. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the Service Provider and any Authorized Entity. Finally, I understand that the Authorized Entities have relied upon my statements contained herein and, on my promise, to fulfill my obligations contained herein.

I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original.

This Consent shall ensure to the benefit of and be binding upon my heirs, agents, spouses, executors, administrators, successors, and assigns. I intend for all Authorized Entities to be third party beneficiaries of the consent I have provided herein.

Signed: ____________________________ Print Name:_________________________ Date:_______________________

My landline telephone number(s):____

My cell telephone number(s): ____