Impact Rehabilitation Center

Patient Registration Form— *Shaded Areas, Office Only* Date:

☐ New Patient ☐ Re-Start ☐ New Diagnosis ☐ New Insurance				**PTPN** ☐ Yes ☐ No
Patient #	**Primary Insurance:** ☐ **Medicare** ☐ **HMO** ☐ **PPO** ☐ **Workers Comp** ☐ **Lien** ☐ **Other** _____			
	Secondary Insurance: ☐ **Medicare** ☐ **HMO** ☐ **PPO** ☐ **Workers Comp** ☐ **Lien** ☐ **Other** _____			
Patient Name (Last, First, Middle Initial)			Gender	Date of Birth
Address	City		State	ZIP Code
Cell Phone ☐ Opt-Out of text messaging ( )	Email ☐ Opt-Out of electronic billing			
Secondary Phone ( )	Social Security # *(Required for VA patients)*			
Referring Physician	Referring NPI (10 digits)	Referring Physician Phone ( )	Treating Therapist	
Patient Status ☐ Active ☐ SFA	Primary location CLINIC	Marital Status	Student ☐Y ☐N	Employment Status
Occupation	Employer			Employer Phone ( )
Address	City		State	ZIP Code

Emergency Contact (Name)	Primary Phone ( )	Relationship to Patient	
Address	City	State	ZIP Code

Financially Responsible Party Other Than Patient

Name (Last, First, Middle Initial)		Relationship to Patient	
Address	City	State	ZIP Code
Primary Phone ( )	Social Security # *(Required for VA patients)*	Gender	Date of Birth

Injury Information

Is condition surgery related? ☐ Yes ☐ No	Date of Surgery	Surgical Procedure		
Is condition accident related? ☐ Yes ☐ No	Was an automobile involved? ☐ Yes ☐ No	Date of Accident		
Describe Accident/Injury/Illness				
Were you injured on the job? ☐ Yes ☐ No	Date of Injury	Are you currently working? ☐ Full-time ☐ Part-time ☐ No		
Name of employer at time of accident		City	State	ZIP Code
Is litigation (lawsuit) involved? ☐ Yes ☐ No	Name of Attorney		Attorney Phone ( )	

Insurance Information

Were benefits and authorization verified? ☐Yes ☐No

Primary Insurance □ In Network □ Out of Network				Pre-Certification ☐Yes ☐No		Pre-Certification Phone ( )	
Claims Mailing Address				City		State	ZIP Code
Subscriber Name				Date of Birth	Sex ☐M ☐F	Relationship to Patient	
ID Card # (including alpha prefix)		Group #			Authorization # / Rx Requirement		
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay $	Visits Per Year / Visits Remaining	□ Soft Max □ Hard Max	
Deductible Start Amount $ (I)/ (F)	Deductible Met Amount $ (I)/ (F)		Out of Pocket Maximum $ (I)/ (F)		Out of Pocket Maximum Met $ (I)/ (F)		
Benefits Verified By	Date	Representative Name/Reference #			Ins. Customer Service Phone ( )		

Secondary/Supplemental Insurance □ In Network □ Out of Network				Pre-Certification ☐Yes ☐No		Pre-Certification Phone ( )	
Claims Mailing Address				City		State	ZIP Code
Subscriber Name				Date of Birth	Sex ☐M ☐F	Relationship to Patient	
ID Card #(including alpha prefix)		Group #			Authorization # / Rx Requirement		
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay $	Visits Per Year / Visits Remaining	□ Soft Max □ Hard Max	
Deductible Start Amount $ (I)/ (F)	Deductible Met Amount $ (I)/ (F)		Out of Pocket Maximum $ (I)/ (F)		Out of Pocket Maximum Met $ (I)/ (F)		
Benefits Verified By	Date	Representative Name/Reference #			Ins. Customer Service Phone ( )		

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

Patient Initials	Date	Front Office	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by ***Impact Rehabilitation Center*** and assigns to ***Impact Rehabilitation Center*** any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes ***Impact Rehabilitation Center*** to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or ***Impact Rehabilitation Center*** for payment of charges to the patient.
4. ***Impact Rehabilitation Center*** reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for ***Impact Rehabilitation Center*****.**

Patient Signature:		Date:
CPM Office Use Only:	*Entered By:*	*Date:*

MEDICAL HISTORY

Name _____

Reason for therapy _____

Date of injury/Onset: _____ Have you had previous therapy for this condition? ( ) Y ( ) N

Surgical Procedure & Date for this condition _____

Have you ever had any of the following tests for this condition? ( ) X-Rays ( ) MRI ( ) CT Scan ( ) EMG ( ) Other

Past Surgical Procedure(s) & Date(s): _____

Please check any of the following whose care you are under,

__ Medical Doctor
__ Osteopath (DO)
__ Dentist
__ Physical Therapist
__ Chiropractor
__ Psychiatrist/Psychologist
__ Other
__ Home Health Care

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, Physical, etc.)

_____

_____

List any medications you are allergic to _____

Any other allergies we should know of? Please list _____

Are you currently taking medications? If so, which one(s) _____

Are you currently experiencing, or have you **EVER,** experienced any of the following?

Diabetes	yes ( ) no ( )	Kidney Problems	yes ( ) no ( )
High Blood Pressure	yes ( ) no ( )	Nervous Disorders	yes ( ) no ( )
Heart Disease	yes ( ) no ( )	Hernia	yes ( ) no ( )
Heart Attack	yes ( ) no ( )	Metal Implants	yes ( ) no ( )
Pacemaker	yes ( ) no ( )	Shortness of Breath	yes ( ) no ( )
Headaches	yes ( ) no ( )	Asthma	yes ( ) no ( )
Seizures/Epilepsy	yes ( ) no ( )	Heart Arrhythmia	yes ( ) no ( )
Cancer	yes ( ) no ( )	Parkinson's	yes ( ) no ( )
Stroke	yes ( ) no ( )	Tuberculosis	yes ( ) no ( )
Heart Murmur	yes ( ) no ( )	Circulation Problems	yes ( ) no ( )
Injured in Motor Vehicle Accident	yes ( ) no ( )	Anemia	yes ( ) no ( )
Emphysema/Bronchitis	yes ( ) no ( )	Depression	yes ( ) no ( )
Hepatitis	yes ( ) no ( )	Rheumatoid Arthritis	yes ( ) no ( )
Chemical Dependency	yes ( ) no ( )	Thyroid Problems	yes ( ) no ( )
Multiple Sclerosis	yes ( ) no ( )	Brain Injury	yes ( ) no ( )
Arthritis	yes ( ) no ( )	Nausea/Vomiting	yes ( ) no ( )
Spinal Cord Injury	yes ( ) no ( )	Weakness	yes ( ) no ( )
Weight Loss/Gain	yes ( ) no ( )	Numbness/Tingling	yes ( ) no ( )
Fatigue	yes ( ) no ( )	Fever/Chills/Sweats	yes ( ) no ( )

Please describe any significant injury(-ies) for which you have EVER been treated (including fractures, dislocations, sprains, etc.) And the approximate date of injury(-ies) _____

_____

Please sign to verify that the above information is true _____

Signature Date

Consent to Treat

Patient's Name: _____

I hereby authorize IMPACT Rehabilitation Center (IRC) and any of its representatives, to treat me and provide medical services related to my treatment. I understand that there are risks related to the treatment of my condition, and willfully accept any and all risks associated with the treatment and care provided for me. I also undertake any exercises or training endeavors, which might be requested of me by my therapy provider, with the full knowledge that there does exist potential for physical injury with adverse physical and/or psychological reaction to them. In participant in the treatment provided at IRC, I do so with the understanding that although IRC will make reasonable efforts to obtain and consider information that might preclude my participation, it is my added responsibility to notify IRC of any condition which should preclude me from the participation in the treatment and services provided.

Patient's Signature: _____ Date: _____

Consent for Minors: As legal guardian, I hereby authorize IRC and any of its representatives to treat and provide medical services related to the treatment of the minor listed above. I agree with the above statement in relation to the minor.

Legal Guardian's Signature: _____ Date: _____

Financial Policy

The following information is provided in addition to the assignment of insurance benefits to avoid any misunderstanding or disagreement concerning payment for professional services rendered.

A medical insurance policy is a contract between you and your insurance company. Coverage depends upon your insurance company and the specific plan you have chosen. It is your responsibility to know and understand your insurance benefits and cost share. _____ Initials

IMPACT Rehabilitation Center will submit claims to your insurance company on your behalf, however it is your responsibility to remit payment for all charges not covered by your claim and insure your carrier remits payment. _____ Initials

All patient cost shares including co-payments, co-insurances, and deductibles are due at the time of treatment. _____ Initials

I authorize IMPACT Rehabilitation Center to charge my credit card on file for my co-pay / co-insurance for each date of service. _____ Initials

For patients with co-insurance and deductible, we will be asking you to pay an estimate of what you will owe for each treatment session. Once your insurance carrier adjudicates the claim, we may have to bill you for the remaining balance. Please note that insurance companies often adjudicate claims for some dates of service a few months after the treatment session concludes. _____ Initials

Cancellation Policy

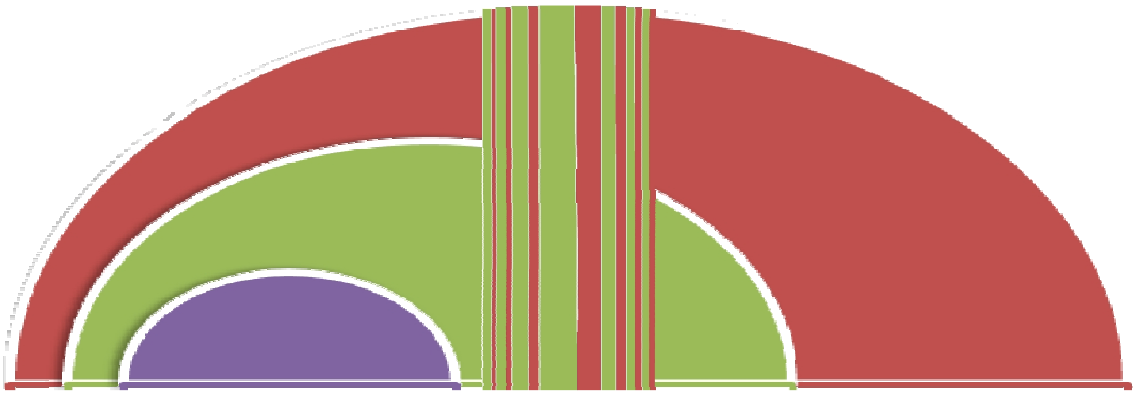
As a courtesy to our staff and other patients, IMPACT Rehabilitation Center requires advance notice for cancellation of appointments. If you need to cancel, please call or text our office the business day prior to your appointment, so as not to incur a cancellation charge. _____ Initials

If you do not call or text to cancel your appointment AT LEAST 2 hours prior to your appointment time, or do not show up for your appointment without notice, a $50 charge will be assessed prior to beginning your next appointment. _____Initials

Thank you for your understanding and courtesy to our staff and other patients.

I, _____, have read, understand, and agree with the above information.

Signature: _____ Date: _____



I have read the material provided me regarding the *HIPAA OMNIBUS Privacy Act*, and understand my rights and choices.

I also have read and understand the material in regard to the clinic's responsibilities under the *HIPAA OMNIBUS Pri-vacy Act*.

I have also been informed that I can obtain further infor-mation regarding the *HIPAA OMNIBUS Privacy Act* at the following website: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

I therefore freely affix my signature below with full un-derstanding of all of the above.

_____ _____

Patient Signature Date

_____

Print Patient Name

_____ _____

Signature of Patient Representative/Guardian Date

_____

Printed Name of Patient Representative/Guardian

_____

Relationship of Patient Representative/Guardian

_____

Patient Name being Represented

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	•• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. •• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	•• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. •• We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	•• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. •• We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	•• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. •• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	•• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. •• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	•• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	•• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. •• We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	•• You can complain if you feel we have violated your rights by contacting us using the information on page 1. •• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/ privacy/hipaa/complaints/.** •• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	•• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	•• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	•• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	•• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law •• For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Instruction C: Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Instruction F: Insert Effective Date of Notice here.

This Notice of Privacy Practices applies to the following organizations.

Instruction G: If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Instruction H: Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.