Today's Date:_____
Date/Time of IE: _____
Treating PT: _____
Staff Initials: _____

IMPACT PHYSICAL THERAPY SPORTS RECOVERY PATIENT INTAKE FORM

PT: ☐ _____ Recovery ☐ ____

Availability:_____

_____

Legal Name:_____
(Last) (First) (Middle)
Preferred/Nickname: _____ Date of Birth: _____

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other: _____ Gender: ☐ Male ☐ Female

Home Address: _____ Apt# _____
City:_____ State:_____ Zip: _____

Phone: _____ E-mail address: _____

(Students attending University) Temp school Address: _____
Apt#_____ City: _____ State: _____ Zip: _____

What is your communication preference? ☐ **Text** ☐ **E-mail**

Emergency Contact Information

Name: _____ Relationship_____ Phone: _____

Were you referred by a Physician? ☐ Yes ☐ No

Referring Physician: _____ Phone: _____
Dx/Reason for Visit: _____ Date of RX (if applicable): _____
Primary Care Physician: _____ Phone: _____

Employer

Employer Name: _____ Phone: _____

How were you referred to IMPACT?

- ☐ Physician/staff
- ☐ Returning Patient
- ☐ Family/Friend
- ☐ Facebook
- ☐ Location
- ☐ Gym _____
- ☐ Google
- ☐ IMPACT Staff _____
- ☐ Website
- ☐ School/Club Sport: _____
- ☐ Insurance
- ☐ Case Manager/Employer _____
- ☐ Recovery Room
- ☐ Other: _____

Revised: 4/29/2025

IMPACT PHYSICAL THERAPY SPORTS RECOVERY

Insurance

Reminder: All deductibles and Copays are due at the time of service

Have you had Physical Therapy/Chiropractic this calendar year? ☐ **Yes** ☐ **No** **If yes, number of visits**_____

Have you been a patient of IMPACT in the past? ☐ **Yes** ☐ **No**

Was this an injury involved in a collegiate sport? ☐ **Yes** ☐ **No** **If yes, date of injury**_____

Health Insurance

Primary Insurance: _____ ID# _____ Group# _____

Insurance Phone:_____

Policy Holder Name:_____ Relationship _____ Date of Birth _____

Claims address: _____

Secondary Insurance: _____ ID# _____ Group# _____

Insurance Phone:_____

Policy Holder Name:_____ Relationship _____ Date of Birth _____

Claims address: _____

Is this an Auto Accident? ☐ Yes ☐ No

Date of Accident _____ City/State accident occurred? _____

Auto Insurance: _____ Policy ID# _____

Insurance Phone: _____

Policy Holder Name: _____ Relationship _____ Date of Birth _____

****Please also provide health insurance information above****

Is this a Work Comp Injury? ☐ Yes ☐ No

Date of Injury: _____ In what City and State did the injury occur? _____

Employer Name: _____ Phone: _____

Address: _____ City:_____ State: _____ Zip: _____

Job Title: _____ Claim number: _____

Insurance Company: _____ Phone: _____

Case Manager/Adjuster: _____ Phone:_____

E-mail: _____

Attorney Name: _____ Attorney Phone: _____

IMPACT PHYSICAL THERAPY SPORTS RECOVERY

Medical History

Patient Name: _____ Age: _____ Sex: F____M _____

What is your main complaint and in what area is it located? _____

_____

Occupation:_____Are you presently working? ☐ Yes ☐ No If no - Last Day Worked: _____

Have you ever had these symptoms before? ☐ Yes ☐ No If yes, When? _____
Have you had physical therapy, occupational therapy or chiropractic care for this injury before? ☐ Yes ☐ No

Which one and when? _____

Check all of those which apply to your current condition:

☐ Work Related Injury	☐ Sports Injury	☐ Motor Vehicle
☐ Accident	☐ Aggravation of Pre-Existing Injury	☐ Causes Unknown
☐ Injury Recurrence	☐ Lifting Injury	☐ Fall

What have you been doing to decrease your pain? _____

On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level? _____

Are your symptoms getting worse/ better/ the same/ since your injury? _____

Are you currently taking any medications? (Please list) _____

_____

Are you allergic to any medications? (If yes, please list) _____

_____

Do you have, or have you had any of the following?

○ Diabetes	○ Cancer	○ Metal Implants	○ Headaches	○ Nausea/Vomiting
○ Chest Pain	○ Asthma	○ Dizziness	○ Kidney Problems	○ Ear Ringing
○ Heart Disease	○ Arthritis	○ Fractures	○ Bladder Problems	○ Hypoglycemia
○ Pacemaker	○ Aids/HIV	○ Skin Allergies	○ High Blood Pressure	○ Seizures
○ Allergies to Cold	○ Allergies to Heat		○ Respiratory Problems	○ Deep Vein Thrombosis (DVT)
○ Recent fall(s) within the past year (How many ___)				

Are You Pregnant ☐ Yes ☐ No
If you answered yes to any of the above, please explain and give an approximate date of occurrence: _____

_____

Please check tests you have had performed: ☐ None ☐ X Rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other _____

Check any of the following activities which you have difficulty with due to your injury:

○ Housekeeping	○ Lifting	○ Driving	○ Shopping	○ Reaching
○ Dressing	○ Cooking	○ Climbing Stairs	○ Child Care	○ Bending
○ Yard Work	○ Sit to Stand			

List all of your surgeries/dates: _____

Is there any other information about your present health that we should know about? _____

_____ _____ _____
Date Patient Signature PT Initials

Revised: 04/29/2025

IMPACT PHYSICAL THERAPY SPORTS RECOVERY

2026

CONSENT FOR CARE AND TREATMENT AND FINANCIAL RESPOSIBILITY

I, the undersigned, do hereby agree and give my consent for IMPACT Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

I acknowledge that I am financially responsible for payment of all services that are not paid by insurance carrier. I understand that all co-payments and self-pay services are due at the time of service. I certify that I was verbally given a statement of a quote of benefits by IMPACT Physical Therapy. If you fail to pay on time and IMPACT refers your account(s) to a third party for collection, a collection fee of 33.3% will be assessed and will be due and owing at the time of the referral to the third party.

I expressly consent to be contacted, by IMPACT Physical Therapy or anyone calling on its behalf, for any and all purposes, at any telephone number, or physical or electronic address I provide or which I may be reached, including any wireless telephone number. I agree that IMPACT Physical Therapy may contact me in any way, including calls or prerecorded or artificial voice or text messages delivered by an automated telephone dialing system, or email address delivered by an automatic emailing system. I acknowledge that this consent cannot be revoked without prior agreement and acceptance by IMPACT Physical Therapy. I agree to promptly notify IMPACT Physical Therapy at any time my contact information changes.

RELEASE OF INFORMATION

I hereby authorize IMPACT Physical Therapy, LLC to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past. I also authorize IMPACT Physical Therapy, LLC practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at any time. By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

CANCELLATION CHARGE CONSENT

If you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance. We will make every attempt to reschedule your appointment. If you miss your appointment without calling in advance, or cancel within 24 hours, you will be charged a $25.00 cancellation fee. You acknowledge that IMPACT Physical therapy will keep a credit card on file through our secure payment system. You also acknowledge that IMPACT Physical Therapy is authorized to process the $25 cancellation fee using the credit card on file. If we do not have a payment on file, IMPACT Physical Therapy will provide an invoice for the $25 cancellation fee.

HIPAA PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice. I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at any time.

In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account. (Optional)

_____ _____

Name/Relationship Contact Number

By signing below, I certify that I have read, understand and fully agree with each of the statements in this document.
I agree to charge credit, debit or HSA card on file for payment toward copay/deductible due:

2026 Deductible is: $_____ 2026 Copay is: $_____ I agree to pay: $_____

Please note: This is a quote of your benefits and not a guarantee of payment. Policies may vary. Always check with your insurance provider to confirm your coverage

_____

Patient/Guardian Name (Print)

_____ _____ _____

Patient/Guardian Signature Date Staff Name/Date

IMPACT
PHYSICAL THERAPY
SPORTS RECOVERY

NOTICE OF PRIVACY PRACTICES

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.

This notice of Privacy Practices has been created by Impact Physical Therapy to inform you of how we may use your protected health information for treatment, payment and health care operations purposes and as otherwise permitted by law. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with regard to accessing, amending and controlling the use of your protected health information.

We will abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice of Privacy Practices at any time as it applies to all protected health information in our custody without providing any notice of such change. Upon the occurrence of any revision of the terms of this Notice of Privacy Practices currently in effect, you may obtain a revised copy of this Notice of Privacy Practices by visiting our website at "www.impactphysicaltherapy.com".

The Privacy Contact for the Provider is: Sarah Jensen. Please direct all questions and requests to the Privacy Contact in writing at P.O Box 220, Westmont, IL 60559.

I. Treatment, Payment and Health Care Operations Following are examples of some, but not all, of the types of uses and disclosures of your protected health care information that we are permitted to make.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another health care provider.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We will disclose to your health insurance company information about the goods and services rendered to you in order to obtain payment from your insurance company.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, face-to-face marketing activities, and conducting or arranging for other business activities.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information, as necessary, to contact you to provide you with information about treatment alternatives or other health- related benefits and services that may be of interest to you.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice.

We may disclose your protected health information to another entity for: health care fraud and abuse detection or compliance, conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions that do not include treatment, reviewing the competence of health care professionals, conducting training programs, accreditation, certification, licensing, credentialing or similar activities.

Disclosures described in the preceding sentence will only be made if the other entity has or had a relationship with you.

We may disclose your protected health information to an organized health care arrangement in which we participate for any health care operation activities of said organized health care arrangement. An example of an organized health care arrangement is a hospital and its medical staff.

II. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization.

Other uses and disclosures of your protected health information for purposes other than treatment, payment and health care operations will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke an authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

III. Uses and Disclosure for Which You Have the Opportunity to Agree or Object.

We may use or disclose your protected health information in the circumstances described in this Section III**,** without seeking an authorization, provided we first give you an opportunity to object to such use or disclosure. If you are present, we may provide you with an opportunity to object and accept your failure to object as your agreement, or we may reasonably infer from the circumstances that you do not object. If you are not present or are unable to agree or object to such use or disclosure of your protected health information, we may use our professional judgment to determine whether the use or disclosure of your protected health information is in our best interest. All communications described in this Section III may be done orally. For example, unless you object, we may disclose your protected health information to your family member, other relative or close personal friend or any other individual identified by you as being a person who is directly involved with your care or payment relating to your care or treatment.

The Right to an Accounting of the Disclosures of Protected Health Information.

You have the right to an accounting of how we have disclosed your protected health information we have made in the six-year period prior to the date of your request for the accounting.

We are not required to account for uses and disclosures of your protected health information by us: to carry out treatment, payment or healthcare operations performed by us or our business associates; to other health care providers to provide treatment to you; to other covered entities or health care providers for payment activities of said persons; to other covered entities which have had a treatment relationship with you for certain health care operations purposes of said entities; to you pursuant to your rights to access your protected health information; made pursuant to an authorization signed by you; to friends and family involved in your care and treatment or payment for your care and treatment, or for certain notification purposes; for national security or intelligence purposes; to correctional authorities with respect to the persons in custody; that occurred prior to April 14, 2003; or incident to a use or disclosure otherwise permitted or required by law.

Your request for an accounting must be made in writing to our Privacy Contact at PO Box 220, Westmont, IL 60559. Your first request in any twelve (12) month period will be provided to you at no charge; however, additional requests will be charged to you based on our cost to conduct the accounting. We will inform you of the fee for the additional accountings prior to our conducting the accounting so that you may consider whether to modify or withdraw your request before you incur any fees.

Right to Receive Paper Notice. If you agreed to receive this notice electronically, you have the right to receive a paper copy of this notice at our office at 1131 S State Street, Chicago, IL 60605.

If you believe your privacy rights have been violated or that we have not complied

with this Notice of Privacy Practices, you may file a written complaint with our Privacy Contact PO Box 220, Westmont, IL 60559 or with the Secretary of the U.S. Department of Health and Human Services. Our Privacy Contact can also be reached by calling 708-590-6663. We will not penalize or charge you for filing a complaint with our Privacy Contact.

VI. Additional Rights; Effective Date.

This Notice of Privacy Practices has been prepared to reflect your rights under the Health Insurance Portability and Accountability Act. If state law provides you with greater access to information, or provides greater protection to that information, than as described in this policy, then we shall follow the provisions of state law. Examples of such state laws are the Mental Health and Developmental Disabilities Confidentiality Act, the AIDS Confidentiality Act and the Genetic Information Privacy Act. In addition, if a Federal law creates greater protection for the information described in this Policy, the Provider shall follow the provisions of such federal law. An example of such a Federal law is the Federal Drug Abuse, Prevention, Treatment and Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment, and Rehabilitation Act of 1970.

The Notice of Privacy Practices is effective as of May 1, 2016.

IV. Uses and Disclosures of Protected Health Information Which Do Not Require Your Authorization or Opportunity to Object.

We are permitted under certain circumstances to make the following uses and disclosures of your protected health information without having to obtain your authorization, or give you an opportunity to object: uses and disclosures required by law; uses and disclosures for public health activities, such as reporting of disease, child abuse, injury, or vital events such as birth or death; disclosure to an employer if you are a member of the employer's work force and we have been requested by the employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury; disclosure to a governmental authority if we reasonably believe that you are a victim of abuse, neglect or domestic violence; disclosure to health oversight agencies (e.g., the U.S. Department of Health and Human Services) for oversight activities authorized by law; disclosures for legal proceedings; disclosures for law enforcement purposes; disclosures concerning decedents; uses and disclosures for cadaveric organ, eye or tissue donation purposes; uses and disclosures for research purposes; uses and disclosures to avert a serious threat to health or safety; disclosures regarding protected health information of members of the armed forces to appropriate military command authorities; national security and intelligence activities; disclosures to correctional authorities regarding protected information of persons in custody; and disclosures as authorized to comply with workers' compensation laws.

V. Your Rights

The Right to Request Restriction of Uses and Disclosures. You have the right to request that we restrict the uses or disclosures of your protected health information to carry out treatment, payment or health care operations and to family members, other relatives or persons directly involved in your care or payment. We are not required to agree to any such restrictions, but if we do, we must comply with such restrictions, other than in an emergency or certain other circumstances permitted or required by law. Consistent with the Hitech Act change, you have the right to request that we limit access to your protected health information. If the disclosure of protected health information is to a health plan for payment of health care operations and member has been paid in full "out of pocket", we will comply with this request. Please submit this request in writing to the Privacy Contact at PO Box 220, Westmont, IL 60559.

The Right to Confidential Communications. You have the right to submit a written request to our Privacy Contact that we provide you with an alternative means of communication in the event you tell us that our customary methods of communication may not preserve the confidentiality of your information. You may request that we send such communications to you to alternative locations. We will attempt to accommodate all reasonable requests.

The Right to Access Protected Health Information. You have a right to submit a written request to our Privacy Contact to inspect and copy your protected health information. Under certain circumstances, we may deny your request to inspect and copy your protected health information.

We may charge a fee for the cost of copying, postage or other items or services involved with your request. You may not remove our records from the premises.

The Right to Amend Protected Health Information. You have the right to submit a written request to our Privacy Contact that we amend your protected health information in our custody, and you must explain the basis for your request. We may deny your request to amend your protected health information if a) we did not create the information unless the individual or entity that created the information is no longer available to make the requested amendment, b) the information is not maintained by or in our custody, c) you do not have the right to access such information, or d) we have determined that such information is accurate and complete.