

Patient Registration

Patient Name: _____ Email: _____
(Last) (First) (M.I.)

Date of Birth: ____/____/____ SSN # ____-____-____ Sex: M F Height: ____ Weight: ____

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

Home #: (____)____-____ Name: _____ Cell #: (____)____-____ Name: _____

Occupation: _____ Student: Full-time or Part-time Marital Status: _____

Parent/Guardian Name: _____ Relationship: _____ DOB: _____

How did you hear about Jaded? _____

Opt into our text message reminder/notifications/home exercise program: Text "JADED" to 39970

We can also send you an opt in text message: ☐ Yes or ☐ No

Current Injury

Date of Injury/Symptoms: _____ Injury/Symptoms Description: _____

Have you missed work due to this injury? Y N If yes, how often? _____

Have you had surgery for this injury? Y N If yes, what procedures and how many? _____

Have you sought care from any other medical providers for this injury/symptom? Y N Exercise: Y N

Frequency and Duration: _____ If female, are you pregnant? Y N Have you had Imaging performed? Y N
If yes, what date and where? _____

Alcohol Consumption: Y N Frequency: _____ Smoking: Y N Amount: _____

Medical History

Primary Care/Referring Physician _____

Current Medications and Dosages: _____

Past Medical and Surgical History: _____

PATIENT SUBJECTIVE

Rate your pain on a scale from **0** (no pain) to **10** (excruciating pain that is disabling)

➤ During the last 48 hours rate your pain at its Best: _____ Worst: _____

During the Night: _____ ➤ Does your pain wake you up at night? YES NO

➤ Does your pain radiate from one area to another? YES NO

➤ Does your pain follow a pattern whereby it is worse in the **AM** or **PM** (circle one if yes)?

➤ Is your pain **constant** or **intermittent** (circle one if yes)?

Please list any activities of daily living that are painful or limited due to your injury?

Please indicate location of pain on diagram:



Left Side



Right Side

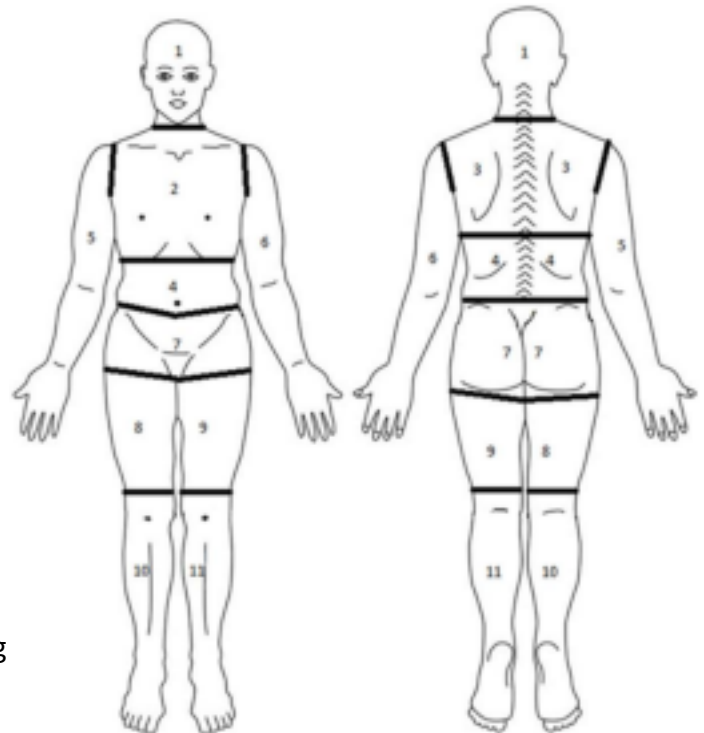


Back Side

Key:

Circle any that apply

- Aching -Stiffness -Tingling
- Tightness -Burning -Shooting
- Stabbing -Numbness -Dull
- Throbbing -Sensitive
- Other -Sharp



Did your referring MD give you any instructions (i.e.: for exercise, weight-bearing, weaning from crutches, use of a brace)? Please elaborate: _____

What are your goals for treatment? _____

CONSENT FOR CARE AND TREATMENT

I, _____, do hereby agree and give my consent for Impakt Performance Medicine, LLC, DBA Jaded, to furnish the medical care and treatment considered necessary and proper in assessing or treating my physical and mental condition.

Signature Patient/Guardian _____ Date: _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Company: _____ Benefits Phone #: (____) _____ - _____
Subscriber/Policy holders Name: _____ DOB: _____ SSN: _____
Policy/I.D. #: _____ Group # _____ Dependent: Y N
Employer: _____

Secondary Insurance:

Insurance Company: _____ Benefits Phone #: (____) _____ - _____
Subscriber/Policy holders Name: _____ DOB: _____ SSN: _____
Policy/I.D. #: _____ Group # _____ Dependent: Y N
Employer: _____

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including that from Medicare, Medicaid, private insurance and third-party payers to Impakt Performance Medicine, LLC, DBA Jaded. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Signature Patient/Guardian: _____ Date: _____

PATIENT HIPAA AWARENESS AGREEMENT

With my permission, Impakt Performance Medicine, LLC, DBA Jaded may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Impakt Performance Medicine, LLC, DBA Jaded Notice of Privacy Practices, located at our front desk, for a more complete description of such uses and disclosures.

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the offices of Impakt Performance Medicine, LLC, DBA Jaded may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care, including laboratory results among others.

With my permission, the offices of Impakt Performance Medicine, LLC, DBA Jaded may mail to my home, or other designated location, any items that assist The Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked

"Personal" and "Confidential". I have the right to request that The Practice restrict how it uses or discloses my PHI to carry out TPO. However, The Practice is not required to agree to my requested restrictions, though if it does so, is bound by this agreement.

By signing this form, I am allowing Impakt Performance Medicine, LLC, DBA Jaded to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that The Practice has already made disclosures in reliance upon my prior consent.

Signature Patient/Guardian: _____ Date: _____

PATIENT AGREEMENT

- ☐ If a patient is more than **15 minutes late** for an appointment Impakt , LLC reserves the right to charge a **\$50 no-show fee**.
- ☐ A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, OR THE PATIENT WILL BE CHARGED a \$50.00 late cancellation fee**.
- ☐ Should a patient miss **two consecutive appointments without calling to cancel**, the patient will be taken off the master schedule and will forfeit all further permanent appointments until a **\$50 no-show / cancellation fee** is collected by the patient and paid to Impakt Performance Medicine, LLC, DBA Jaded.
- ☐ Physical therapy is by physician referral and appointment only, unless your insurance is direct access approved.
- ☐ If any changes are made to patient insurance/payment coverage, patient agrees to alert Impakt Performance Medicine, LLC, DBA Jaded as soon as possible to these changes.
- ☐ Impakt Performance Medicine, LLC, DBA Jaded will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made the day of your appointment.
- ☐ If your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.
- ☐ If your claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the usual amount of charges for services rendered to you.
- ☐ I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to Impakt Performance Medicine, LLC, DBA Jaded, including court costs, collection agency fees and attorney fees.
- ☐ Full payment of your outstanding deductible and all initial co-payments are to be made directly to Impakt Performance Medicine, LLC, DBA Jaded at the time of the initial visit. Subsequent physical therapy co payments (and cancellation fees assessed) are to be made at the time of each visit.

I, _____, agree to treatment on the above terms:

Signature Patient/Guardian Date

AGREEMENT FOR NON-COVERED SERVICES AND SERVICES DETERMINED TO BE “NOT MEDICALLY NECESSARY”

The office of Impakt Performance Medicine, LLC, DBA Jaded has explained to me that the benefits for services requested may not be considered “Medically Necessary” by my insurance company. I have decided to receive the following services which may be non-covered or considered “Not Medically Necessary”. Impakt Performance Medicine, LLC, DBA Jaded will do their best to verify my benefits at time of service; however, it is a quote of benefits and not a guarantee of payment. Since an insurance plan is a contract between me and the insurance carrier, it is ultimately my responsibility to be aware of my insurance benefits. Any services not covered or deemed “not medically necessary” are my financial responsibility. I have agreed to receive any services necessary from the list below.

<u>CPT Codes</u> (units)	<u>Service</u>	<u>Price</u> (15 min units)
97161,2,3	Initial Evaluation (Low, Medium,	\$180
97164	High) Re-evaluation	\$115
97140	Manual Therapy	\$75
97110	Therapeutic Exercise	\$93
97010	Hot/Cold Pack Therapy	\$75
97018	Paraffin	\$50
97530	Therapeutic Activity	\$72
97035	Ultrasound Therapy	\$60
97116	Gait Training	\$80
97033	Iontophoresis	\$80
97535	Self-Care Management	\$70
97014	Electro-Stimulation	\$55
97032	Electro-Stimulation (1x1)	\$55
97012	Mechanical Traction	\$56
97112	Neuromuscular Re-education	\$86
97760	Orthotic Fitting/Training	\$67
97762	Orthotic Follow-up	\$75
L3020	Right Custom FAB Orthotic	\$180
L3020	Left Custom FAB Orthotic	\$180

I am aware these services may or may not be determined by my health insurance policy and/or certificate to be “not medically necessary” and may or may not become non-covered services for the complete duration of treatment for my illness, injury or condition. If the services are not covered or considered not medically necessary by my health insurance policy and/or certificate, I agree to be financially responsible for such services.

Signature of Patient/Guardian Date

Cancellation & Credit Card on File

At Impakt Performance Medicine, LLC, DBA Jaded, we require a credit or debit card to be on file for your convenience. This is to pay for the portion of services that your insurance doesn’t cover, but for which you are liable.

Your card may be charged after notifying you of any additional charges. For example, a portion of your visits that wasn’t charged at the time of your appointment or was charged incorrectly after receiving your insurance’s explanation of benefits (EOB).

In addition to the information stated above we require keeping your credit or debit card on file as a method

of payment if a patient is more than **15 minutes late** for an appointment or a scheduled appointment that has not been cancelled within at **least 24 hours' notice**. In these Cases, Impakt Performance Medicine, LLC, DBA Jaded **reserves the right to charge a \$50 no-show / cancellation fee**.

Your credit card information is kept confidential and secure.

Credit Card Information	
NAME: _____	CVV: _____
CARD: _____ - _____ - _____ - _____	Exp: ____ / ____

Billing Address: _____ (Only if different than what's on the Registration form)

City: _____ State: _____ ZIP: _____

I (we), the undersigned, authorize and request Impakt Performance Medicine, LLC, DBA Jaded to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility and any no-show or canceled appointments not received before **24 hours** of your scheduled appointment.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Impakt Performance Medicine, LLC, DBA Jaded in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: ____ / ____ / ____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (Optional)

Patient's Name: _____

Date of Birth: _____

SSN: _____

I authorize **Impakt Performance Medicine, LLC, DBA Jaded** to request and receive healthcare information of the patient named above.

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates:
- ☐ All healthcare information ☐ Other:

What is authorization to release healthcare information:

A medical records release is a written authorization for Impakt Performance Medicine, LLC, DBA Jaded to receive your healthcare information from another healthcare provider's office with your authorization. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state laws mandate that health providers do not disclose a patient's information without a valid authorization except in limited circumstances as required or permitted by law.

Patient Name (Print): _____

Patient Signature: _____ Date: ____/____/____