IMPACT
HEALTH AND PERFORMANCE

CLIENT INFORMATION

•• Impact Health is OUT OF NETWORK with all insurance companies and we do not submit claims. However, upon request, we will provide detailed statements with insurance coding for reference ••

Client Name: _____ Married / Single / Other

Date of Birth: _____/_____/_____ Phone: _____

Primary Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

How did you hear about IMPACT? _____

Emergency Contact Name/Number_____

Today's Payment by: Cash _____ Check _____ Credit/Debit Card _____

Current Condition: _____

Onset Date: _____ Limitations: _____

Prior Treatment for condition: _____

Medical/Surgical History: _____

Allergies/Other: _____

CANCELLATION/NO SHOW POLICY

Missed appointments or those cancelled less than 24-hr business day notice will be charged a $50 fee.

Client Acknowledgement _____ Impact Health Staff _____
(Initials) (Initials)