



Medical History Questionnaire

Name: _____ Date of Birth: _____ Sex: Male Female

Address: _____
Street City, State Zip

Home Phone: (____) _____ Work: (____) _____

Cell Phone: (____) _____ Cell Phone Provider _____

May we send you text message appointment reminders? Yes No

*A confidential message (i.e. appointment reminders) may be left on your voicemail or by text message.

Social Security #: _____

Employer: _____

Employer Address: _____
Street City, State Zip

EMERGENCY CONTACT – Name: _____

Relationship: _____ Phone: (____) _____

Responsible Party (if different than above):

Name: _____	Date of Birth: _____
Social Security #: _____	
Address: _____	
<i>Street</i>	<i>City, State</i>
<i>Zip</i>	
Home Phone: (____) _____	Work: (____) _____ Cell: (____) _____

Allergies (including latex): _____

List all medications that you are currently taking, either prescription or non-prescription.

Do you use tobacco products? Yes No If yes, how many times per day? _____

Do you drink alcoholic beverages? Yes No If yes, how many drinks per week? _____

Are you pregnant? Yes No If yes, how many weeks? _____

Do you have a pacemaker? Yes No Are you taking blood thinners? Yes No

Please list any other health care professionals who are assisting you with this condition. _____

Patient Name: _____

Injury Information:

Condition is related to: Work Auto Home Sports Other None

How did you hear about us? _____

Have you had any therapy services this calendar year? Yes No

If YES, where did you have the services: _____

Referring Physician: _____ Primary Care Physician: _____

Patient (or Guardian) Signature: _____ **Date:** _____

Informed Consent

I consent to treatment rendered by Horizon Physical Therapy and Rehabilitation, Inc., Inc. as ordered or approved by my physician. I agree to participate in Horizon Physical Therapy and Rehabilitation, Inc.’s program to the best of my ability to facilitate a rapid and full recovery.

I consent to having my picture taken for objective analysis of my condition. This information will be used solely for the purpose of education of myself for my condition and to compare pre and post treatment outcomes. Any other use of this information will require my written consent.

I understand that some increase in pain may be normal. I must determine how much pain increase is acceptable to me, and I may be asked to describe any pain using a Visual Analog Scale. I will not be asked to perform activities that increase my pain to a level that is unsafe or undesirable to me. I will be asked to perform activities, but will not be forced to perform any activity that I believe unsafe. I will be informed if I’m seen doing anything unsafe or that jeopardizes my recovery.

Consent for Release of Information

Insurers may release to Horizon Physical Therapy and Rehabilitation, Inc. any information regarding the extent of my insurance coverage, information concerning the status of claims submitted by Horizon Physical Therapy and Rehabilitation, Inc. and information regarding payments made directly to me on those claims. Horizon Physical Therapy and Rehabilitation, Inc. may obtain any information and/or medical records pertinent to “treatment” provides from hospitals, physicians, nursing agencies, and other health care providers. Pursuant to the privacy rule 45CFR164.501 of HIPAA, “treatment” generally means the provision, coordination, or management of health care and related services among providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Receipt of Privacy Practice Notice

I understand that Horizon Physical Therapy and Rehabilitation, Inc. has provided me with a copy of their Notice of Privacy Practices, which states how my personal health information (PHI) may be used or disclosed and outlines my rights regarding this information. I understand that Horizon Physical Therapy and Rehabilitation, Inc. has the right to change this notice at any time and that I must request in writing any objections to any of these “uses” or “disclosure”. I may obtain an additional copy of this notice from this office per my request.

Please check one of the following statements:

- I received a copy of the Privacy Practices.
- I declined a copy of the Privacy Practices.

Authorization for Disclosure

I, a patient of Horizon Physical Therapy and Rehabilitation, Inc., Inc., give my expressed permission to discuss with the individuals I have listed:

- Any aspect of my health care**
- Health Information only**
- Financial information only**

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

Assignment of Benefits

I understand that I am ultimately responsible for the charges incurred for my services at Horizon Physical Therapy and Rehabilitation, Inc. whether the benefits are through Commercial Insurance, Workers’ Compensation or a Third-Party Payer (i.e. auto accident).

I also understand that additional information may be required of me to assist Horizon Physical Therapy and Rehabilitation, Inc. in filing such claims. I may have to provide information from the following list regardless of my insurance:

- Social Security Number
- Date of Birth
- Copy of Insurance Card (for commercial filing and/or workers’ compensation)
- Name of employer, Employer address, phone number and contact person
- Auto Insurance

Horizon Physical Therapy and Rehabilitation, Inc. will file my insurance claims as a courtesy, and understands that any quoted benefits given at the time of service are not a guarantee of payment. I assign all benefits paid by the insurance to be paid directly to Horizon Physical Therapy and Rehabilitation, Inc. By my signature below I acknowledge my responsibility and assign said benefits and verify that I have read and agree to the terms of Horizon Physical Therapy and Rehabilitation, Inc. Payment Policy.

Signature of Patient/Guardian

Date

Witness