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: ____
Street *City, State*
Zip
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

Is a home health agency currently providing services in your home? Yes No

Do you currently reside in an assisted living or nursing home facility? Yes No

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 clams 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

PAYMENT & NO SHOW/CANCELLATION POLICY

In an ongoing effort to better serve our patients, Horizon Physical Therapy and Rehabilitation, Inc., will use reasonable efforts to obtain benefit information from your insurance carrier for outpatient rehabilitation services. Because your insurance carrier typically does not guarantee either the benefits it provides to us on your behalf, or the payment for services rendered to you, your carrier's benefit information which we provide to you may not be completely accurate. We will not know exactly what your coverage of expenses will be until we have received reimbursement from your insurance carrier at which time you are responsible for the balance of all unpaid claims.

Horizon Physical Therapy and Rehabilitation, Inc. wishes to make payment for your account balance as convenient for you as possible. Insurance companies require the separate filing of our professional fees for each date of service. As a courtesy to you, we customarily file your claims with your insurance company. Each patient, however, remains fully responsible for the entire amount of the bill until all claims are paid.

Payment for any deductible, co-insurance, or copayment is expected at the time services are rendered. If our staff is unable to confirm that you have insurance coverage, payment of your charges in full is requested at the time of service. Any payment due may be paid in cash, personal check, or credit card. If the unpaid balance exceeds 30 days with Horizon Physical Therapy and Rehabilitation, Inc., the unpaid balance will be subject to a 1.5% finance charge each month (18% annually).

If you are unable to comply or if you have any questions concerning our payment policy, our Front Office Coordinator will be happy to assist you.

Overdue Account Balances

It is unfortunate when no arrangements for payment can be made or agreed upon and accounts become delinquent. Any account that is 90 days past due may be considered a bad debt risk. When this happens, we may have no recourse but to assign your account to a third party collection agency for collection or place your account with an attorney to obtain judgment or otherwise satisfy payment of your delinquent account. If this occurs, a collection fee of up to 30% of the unpaid balance will be added to your account. We will also charge reasonable attorney fees, court costs, interest, late fees, and sheriff's fees.

No Show/Cancellation Policy

Twenty-four hours' notice is required for all cancellations and rescheduled appointments. Upon a second cancellation or rescheduling occurring less than twenty-four hours from your scheduled appointment time, a fee of $25.00 will be billed to your account. Subsequent cancellations of less than twenty-four hours or "no show" appointments will also incur a $25.00 late cancellation fee. Three cancellations of less than twenty-four hours prior to appointment time or three "no shows" will result in discharge.

I, the undersigned, have read and understand the Payment and No Show/Cancellation Policy as outlined above.

______________________________ ______________

Patient or Guardian Signature **Date**