Office Use:
Verified DL/Photo ID ☐
Verified Insurance Card(s) ☐

Patient Information Form

First Name: ______________________ Last Name: ______________________ Sex: ☐F ☐M
DOB: ____________________ Status: ☐Single ☐Married ☐Other SSN: ________________
Phone/Cell: __________________
Address: __________________________ City: ________________ State: _____ Zip: ________
Text Reminders: ☐ Yes ☐ No Email: ______________________________ ☐ Declined Email
Emergency Contact: ____________________________________ Phone: ______________________
Ref. Physician: ____________________________ Phone: ________________ RX Date: __________

Employer: ____________________________________ Status: ☐FT ☐PT ☐None ☐Retired ☐Student
Occupation: __________________________________

Injury/Onset Date: ________________________ Body Part/DX: __________________________
Post-Surgical: ☐Yes ☐No Surgery Date: __________________
Have you had prior therapy this year (PT/OT/ST/Chiro): ☐Yes ☐No If yes, how many: ____________
How did you hear about us? ____

Work Comp

Work Related: ☐Y ☐N | Accident Related: ☐Y ☐N | Auto Related: ☐Y ☐N | Attorney Involved: ☐Y ☐N
Adj/Nurse Case Mgr.: ________________________________ Phone: ________________________
Attorney: ____ Phone: ________________________

Medicare

If Medicare, are you currently Receiving Home Health Services? ☐Yes ☐No
If YES, Name of Agency: ____ D/C Date: ____________

Consent of Treatment

I am aware of my diagnosis and voluntarily consent to have Horst Physical Therapy, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical, speech, and occupational therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Horst Physical Therapy is limited to physical, speech, and/or occupational therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during my care.

Please sign if the above information is correct and complete.

Signature: ______________________________________ Date: ____________

Notification of Patient Financial Responsibility

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-pays at the time of service and for any deductible or coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement.

I have read the above policy regarding my financial responsibility to Horst Physical Therapy for providing rehabilitative services to the above-named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Horst Physical Therapy. I agree to pay Horst Physical Therapy the full and entire amount of all bills incurred by me or the named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature____ Date ___________

You agree that for us to collect any amounts you may owe; we may contact you by any telephone number associated with your account. We may also contact you by sending text messages or emails, using any email address you provide to us.

Signature____ Date ___________

Insurance: ____________________ Plan: ________
Policy ID#: ________________________________
Group #: __________________ Auth: ☐Y ☐N
Phone: __________________
Subscriber: ____________________ DOB: _______
Relation to Subscriber: ☐Self ☐Spouse ☐Child

Office Use
Reference #____________________________
Rep Name:_____________________________

Insurance: ____________________ Plan: ________
Policy ID#: ________________________________
Group #: __________________ Auth: ☐Y ☐N
Phone: __________________
Subscriber: ____________________ DOB: _______
Relation to Subscriber: ☐Self ☐Spouse ☐Child

Office Use
Reference #____________________________
Rep Name:_____________________________

Office Use:

Copay: ___________________ Deductible:____________________ Co-Insurance:________________

Out of Pocket Maximum: ______________________________ Visit Limit:____________________HC/SC

____

Estimated Cost: Eval ____________________________ Follow Up ______________________________

NOTE: ESTIMATED coverage information is provided as a courtesy to our patients that have deductible/ coinsurance applicable but is not intended to release them from total responsibility of their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No
May we leave a message on your answering machine at home or on your cell phone? ☐ Yes ☐ No
May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

If YES, please name the members allowed:

____

____

Signature:____ Date: ________________

Medical History Form

Patient Name: ______________________________

Height:_____ft_____in Weight: __________ Date of injury: ______________________

Injury/Aliment: ______________________________

How did this injury occur? ______________________________

Have you been hospitalized for the present condition? ☐ Yes ☐ No If Yes, date: ____________________

Have you had surgery for the present condition? ☐ Yes ☐ No If Yes, date: ____________________

If yes, surgery type: ______________________________

Have you had any falls this past year? ☐Yes ☐No If Yes, how many? __________

Have you received previous treatment for this condition? ☐Yes ☐No If Yes, date: ____________________

If yes, please summarize: ______________________________

Have you ever had any of the following for this condition? ☐EMG ☐CT SCAN ☐ MYELOGRAM ☐MRI ☐XRAY

Are you on any medications? Check if attached: ☐ Attached Please list: (you may use reverse side)

____

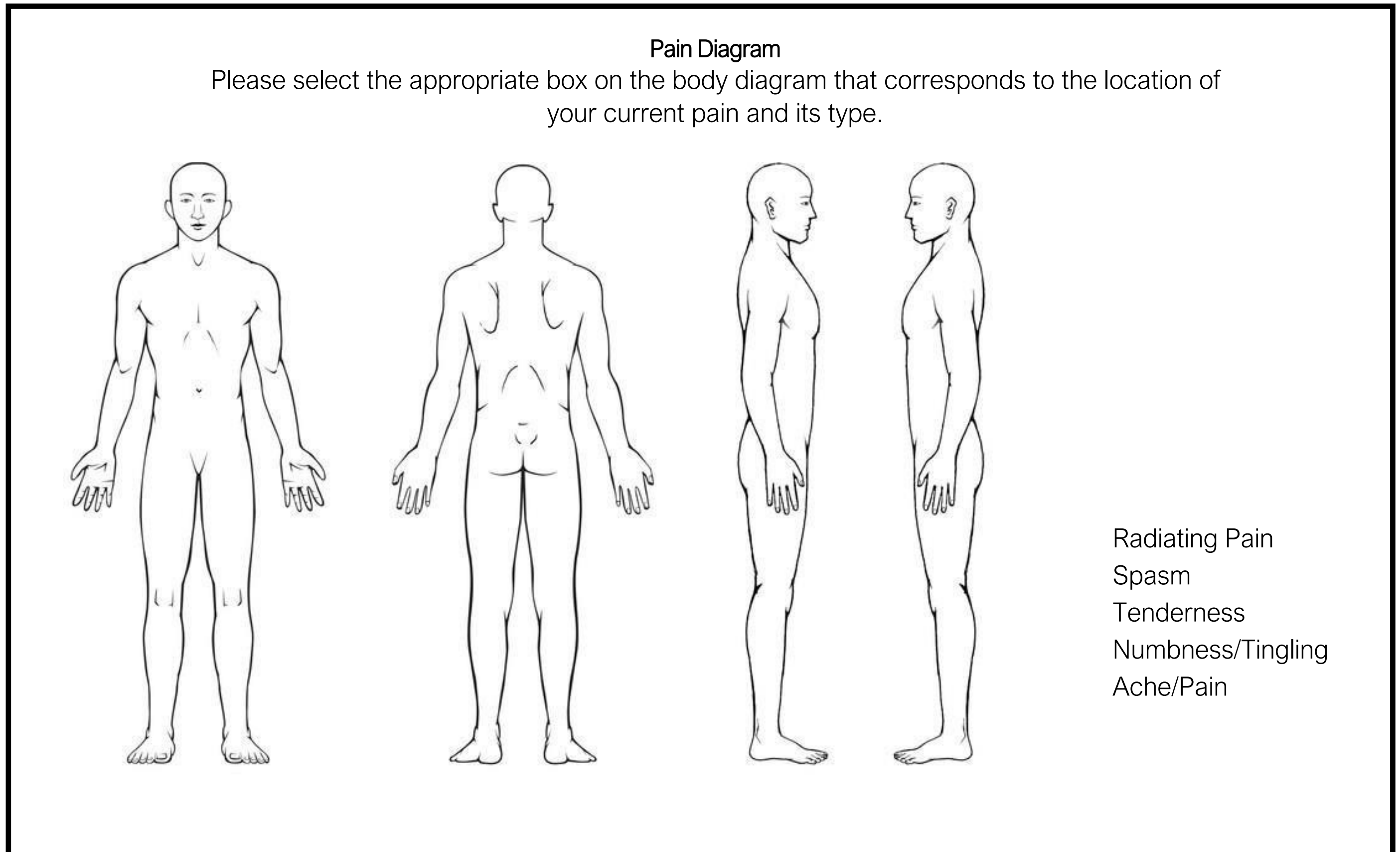
____

To help us understand your symptoms, please check all that apply.

My pain is worse: ☐ in the morning ☐ constant
☐ during the day ☐with activity
☐ at night ☐during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best ________ and at its worst __________



Please continue to 2nd page

HORST PT
Strength. Mobility. Function.

Have you ever, or are you presently being treated for any of the following?

Condition	Yes	No	Condition	Yes	No
Acquired Respiratory Distress Syndrome	☐Yes	☐No	Allergies	☐Yes	☐No
Anxiety or Panic Disorders	☐Yes	☐No	Bleeding Disorders	☐Yes	☐No
Arthritis (RA, OA)	☐Yes	☐No	Bowel / Bladder Abnormalities	☐Yes	☐No
Asthma	☐Yes	☐No	Cancer- Type:	☐Yes	☐No
Chronic Obstructive Pulmonary Disease (COPD)	☐Yes	☐No	Defibrillator	☐Yes	☐No
Skin Abnormalities	☐Yes	☐No	Dizzy or Fainting Spells	☐Yes	☐No
Congestive Heart Failure (CHF)	☐Yes	☐No	Epilepsy or Seizure Disorder	☐Yes	☐No
Degenerative Disc Disease	☐Yes	☐No	Fracture- Type:	☐Yes	☐No
Depression	☐Yes	☐No	Headaches	☐Yes	☐No
Angina	☐Yes	☐No	Hepatitis A, B, C	☐Yes	☐No
Diabetes	☐Yes	☐No	Hernia	☐Yes	☐No
Emphysema	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Hearing Impairment	☐Yes	☐No	HIV/AIDS	☐Yes	☐No
Heart Attack	☐Yes	☐No	Hypoglycemia	☐Yes	☐No
Multiple Sclerosis	☐Yes	☐No	Immunosuppressant Condition	☐Yes	☐No
Osteoporosis	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Parkinson's Disease	☐Yes	☐No	Liver / Gallbladder Problems	☐Yes	☐No
Peripheral Vascular disease	☐Yes	☐No	Additional Surgeries - List Below	☐Yes	☐No
Stroke or TIA	☐Yes	☐No	Nausea / Vomiting	☐Yes	☐No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	☐Yes	☐No	Pacemaker	☐Yes	☐No
Visual Impairment (cataracts, glaucoma, macular degeneration)	☐Yes	☐No	Currently Pregnant	☐Yes	☐No
Smoking (Active)	☐Yes	☐No	Ringing in Your Ears	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Sexual Dysfunction	☐Yes	☐No
	☐Yes	☐No		☐Yes	☐No

Is there any other information regarding your medical history that we should knowabout? ____________________

____

Signature of Patient or Guardian (if patient is a minor): ____________________________________Date: __________