Verified Insurance Card(s) ☐

HORST PHYSICAL THERAPY
STRENGTH. MOBILITY. FUNCTION

Patient Information Form

First Name: _____ Last Name: _____ Sex: ☐F ☐M

DOB: _____ Status: ☐Single ☐Married ☐Other SSN: _____

Phone/Cell: _____

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

Ref. Physician: _____ RX Date: _____

Emergency Contact: _____ Phone: _____

Text Reminders: ☐ Yes ☐ No Email: _____

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: _____

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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:_____

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.

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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

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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:

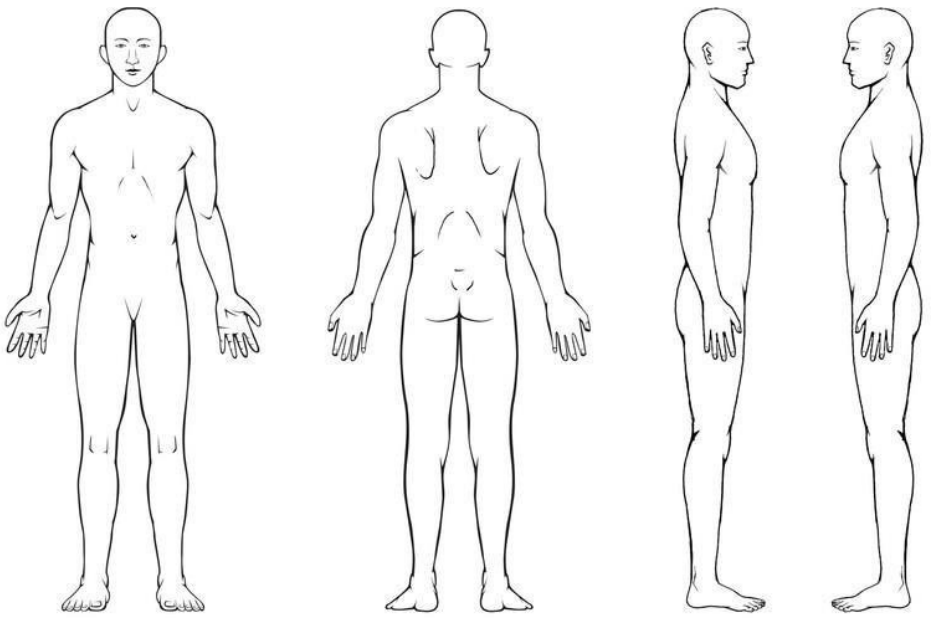
☐ in the morning	☐ constant
☐ during the day	☐with activity
☐ at night	☐during rest

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 _____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



KEY

↑or↓: Radiating Pain
XXX: Spasm
ZZZ: Tenderness ///: Numbness/Tingling
000: Ache/Pain

Please continue to 2nd page

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

Acquired Respiratory Distress Syndrome	☐Yes
Anxiety or Panic Disorders	☐Yes
Arthritis (RA, OA)	☐Yes
Asthma	☐Yes
Chronic Obstructive Pulmonary Disease (COPD)	☐Yes
Skin Abnormalities	☐Yes
Congestive Heart Failure (CHF)	☐Yes
Degenerative Disc Disease	☐Yes
Depression	☐Yes
Angina	☐Yes
Diabetes	☐Yes
Emphysema	☐Yes
Hearing Impairment	☐Yes
Heart Attack	☐Yes
Multiple Sclerosis	☐Yes
Osteoporosis	☐Yes
Parkinson's Disease	☐Yes
Peripheral Vascular disease	☐Yes
Stroke or TIA	☐Yes
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	☐Yes
Visual Impairment (cataracts, glaucoma, macular degeneration)	☐Yes
Smoking (Active)	☐Yes
Tuberculosis	☐Yes
	☐Yes

Allergies	☐Yes
Bleeding Disorders	☐Yes
Bowel / Bladder Abnormalities	☐Yes
Cancer- Type:	☐Yes
Defibrillator	☐Yes
Dizzy or Fainting Spells	☐Yes
Epilepsy or Seizure Disorder	☐Yes
Fracture- Type:	☐Yes
Headaches	☐Yes
Hepatitis A, B, C	☐Yes
Hernia	☐Yes
High Blood Pressure	☐Yes
HIV/AIDS	☐Yes
Hypoglycemia	☐Yes
Immunosuppressant Condition	☐Yes
Kidney Problems	☐Yes
Liver / Gallbladder Problems	☐Yes
Additional Surgeries- List below	☐Yes
Nausea / Vomiting	☐Yes
Pacemaker	☐Yes
Currently Pregnant	☐Yes
Ringing in Your Ears	☐Yes
Sexual Dysfunction	☐Yes
	☐Yes

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

_____

Signature of Patient or Guardian (if patient is a minor): _____Date: _____