Welcome to Horizon Wellness. We are excited you have chosen us for your physical therapy needs. Your provider will differentially diagnose your problem through assessment and perform neuromuscular re-education to maintain a pain free state after you are discharged. Your treatment will be provided in a relaxed therapeutic environment. It is part of our mission to ensure that you are fully satisfied with your care, and everyone at our clinic will work hard to make your experience exceptional.

Important information:

- **If you did not complete the admission forms prior to your visit, please complete them now.**
- We will need a copy of your insurance card and driver's license, as well as the prescription from your doctor.
- **If your insurance requires you to pay a copay and/or coinsurance, please plan to pay this at each visit.**
- You may be asked to wear shorts if you are being treated for a low back, hip, or knee problem. You may bring shorts with you or use a pair from our supply.
- **Plan for your appointments to last 45-60 minutes.**

Insurance Verification
As a courtesy, we will verify your insurance benefits with your provider. At your request we will provide you with information regarding your policy allowances for physical therapy services. You will receive EOBs from your insurance company as well as a monthly statement from us. This statement will indicate the amount that was billed to your insurance company. **Please note that your insurance company will determine the amount they will pay for services based on your policy**. *You are responsible for partial or total payment of the balance. Ultimately, you are responsible for understanding the benefits and eligibility of your policy.*

Equipment Charge
As we do issue items such as exercise bands, noodles, balls, etc. during your rehabilitation and/or use specialized equipment for your treatment, there is a ***one time ten dollar fee***. **This fee is due at the end of the first visit.** This fee excludes durable medical goods and special order items, which will be billed separately if needed for your care.

Thank you again for choosing Horizon Wellness, we look forward to working with you!
Please sign below signifying that you understand and accept our policies. Thank you.

Patient Signature_____Date_____
(Parent/Guardian signature if patient is under the age of 19)

Sincerely,

Horizon Management

Financial Agreement

I understand and agree that I am responsible for payment for services performed at Horizon Wellness. I will pay upon demand, all charges that are my responsibility. I authorize all payments be made from my insurance company to Horizon Wellness and I am responsible for all charges not paid by my insurance company. I authorize Horizon Wellness to provide information necessary to secure payment of benefits**.**
I understand that any balance beyond 90 days will be assessed an outstanding balance fee.

$30 for returned checks.

Please initial_____

Use of Protected Health Information (HIPPA)

I have been offered or provided with a Notice of Privacy Practices. I understand that Horizon Physical Therapy, PC may disclose my personal health information for the purpose of carrying out treatment and obtaining payment. I hereby consent the use and disclosure of my personal health information as described in the Notice of Information Practices. I understand I can revoke this consent by notifying the practice in writing at any time. I have been offered a copy of the Notice of Privacy Practice.

Please initial_____

Authorization for Treatment

I hereby consent to and authorize all physical therapy, chiropractic, and massage treatments at Horizon Wellness.

Printed Patient Name_____

Signature_____Date_____

(Parent/Guardian Signature if patient is under the age of 19)

Patient Information Form

Patient Information

Today's Date_____
Referring Physician _____Primary Physician_____
Onset of Pain_____
(MM/DD/YYYY)

Last Name _____First Name _____Middle Initial_____
Address_____
City, State _____ Zip Code _____

Social Security Number ____-____-____Date of Birth ____/____/____ Gender: □ Male □ Female
Home Phone (____) ____-____Mobile Phone (____) ____-____ Work Phone (____) ____-____
Email Address_____
for use by Horizon PT only will not be shared with any outside agencies

Employer _____Work Address _____
Were you injured at work? □ Yes □ No Date of Injury_____
If yes, explain_____
Are you here because of an auto accident? Yes □ No Date of Injury_____
If yes, explain_____

Spouse Information/ Parent or Guardian (if applicable)
Last Name _____First Name _____Middle Initial_____
Social Security Number ____-____-____Date of Birth ____/____/____Gender: □ Male □ Female
Home Phone _____ Mobile Phone_____ Work Phone_____

Insurance Policy Holder Information
Last Name _____First Name _____Middle Initial_____
Relationship to Patient_____
Address_____
City, State _____ Zip Code_____
Social Security Number ____-____-____ Date of Birth ____/____/____ Gender: Male Female
Home Phone (___) ____-____ Mobile Phone (____) ____-____

Emergency Contact (someone not living with you)
Name_____Relationship_____
Home Phone (____) ____-____Work Phone (____) ____-____ Mobile Phone (___) ____-____

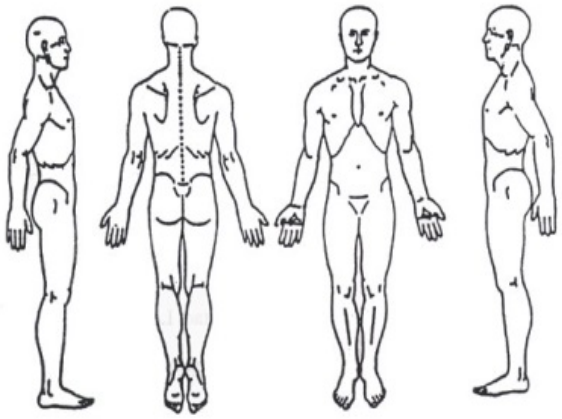
How did you hear about Horizon Wellness? _____

Medical History Form

Name: _____ Date: _____

Date of next MD appointment: _____

What body part are you being seen for?_____ ***Please* indicate body area below**



In regards to what you are being seen for, please rate your pain on the lines below and mark areas of pain on the body chart to the right:

0= No Pain 10= Emergency Room Pain

At Worst: 0 1 2 3 4 5 6 7 8 9 10

Currently: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

Please describe your pain, circle all that apply:

Numbness Tingling Ache Burn Sharp Dull

What makes your pain worse?: _____

What makes your pain better? _____

<u>Personal Medical History:</u>

Do you have, or have you ever had:

Heart Disease	Yes	No	Heart Attack	Yes	No
Osteoporosis	Yes	No	Bleeding Disorders	Yes	No
Joint Replacement	Yes	No	Fibromyalgia	Yes	No
Blood Clots	Yes	No	Myofascial Pain Syndrome	Yes	No
Angina/Chest pain	Yes	No	Thyroid Problems	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No

Fracture	Yes	No	Parkinson Disease	Yes	No
Diabetes I II	Yes	No	Headaches	Yes	No
Stomach Problems	Yes	No	Depression	Yes	No
Chronic Bronchitis	Yes	No	Anxiety	Yes	No
Emphysema	Yes	No	Bipolar	Yes	No
Shortness of Breath	Yes	No	Cancer	Yes	No
Asthma	Yes	No	Type: _____		
HIV/AIDS	Yes	No	Treatment: _____		
Skin Disorders	Yes	No			
Aneurysm	Yes	No	Pregnant	Yes	No
Stroke	Yes	No	Implants (joint, breast pacemaker, etc.)		
Epilepsy/Seizures	Yes	No		Yes	No
Multiple Sclerosis	Yes	No	If Yes, where_____		

Surgeries: Please list with approximate dates: _____

_____

General Health:

How would you rate your health? Excellent Good Fair Poor

Do you exercise regularly? Yes No

Describe: _____

Have you had any diagnostic tests (MRI, X-ray, lab, CT scan) recently? If yes, please list: Yes No

_____

Medications: *(If you have a medication list with you the front office will take a copy of it for the therapist)*

Please list any current prescriptions or over-counter-medications, supplements, or herbal products:_____

_____

_____

What are your goals you hope to obtain with Physical Therapy?

_____

_____

_____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____