GENERAL MEDICAL HISTORY FORM

Name: ___________________________________ Age _______ SSN: _______________Date:________
Contact Numbers (Home/Work): ______________________EMAIL:____________________________
Emergency Contact & Number:____
Referring Physician: ____

PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Have you received a therapy assessment or treatment within the current year? Y N
2. Are you currently under Home Health Care or Hospice? Y N
3. Have you had surgery for this injury within the last 8 weeks? Y N
4. Have you had a cast removed from the injured body part within the last 2 weeks? Y N
5. Is this injury the result of a workplace accident? Y N
6. Is this injury the result of a motor vehicle accident that has occurred within the last 90 days? Y N

TO RULE OUT CONTRAINDICATIONS TO TREATMENT, MARK AN “X” IN THE APPROPRIATE BOX IF YOU HAVE EVER SUFFERED ANY OF THE FOLLOWING HEALTH PROBLEMS.

__Seizures/stroke __Bleeding problems __Diabetes __Osteoporosis __Blood clots
__Blood pressure __Chest pain/angina __Cancer __Anemia __HIV

INDICATE WITH AN “X” WHICH OF THE SYMPTOMS BELOW YOU PRESENTLY SUFFER FROM.

__Shortness of breath __Nausea/vomiting __Numb/tingling
__Difficulty swallowing __Changes in bowel function __Changes in bladder function
__Increased pain at night __Fever/chills/sweats __Dizziness

HISTORY OF PRESENT INJURY

What part of your body is presently injured?____
What Medications are you currently taking?____
Pain Medications? Y N Please List ____
Anti-Inflammatories? Y N Please List ____
When/How were you injured? ____
How were you referred to us? __Physician __Friend, if so whom?____________________________
__Print Ad __Previous experience with clinicians

ACKNOWLEDGEMENT

I have completed this form to the best of my knowledge and ability.

Patient’s Signature:____ Date ____________________

FINANCIAL POLICY & CONSENT FORM

Thank you for choosing **Horizon Rehabilitation & Sports Medicine** as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement we require you to read and sign prior to any treatment.

OUR FINANCIAL POLICY

REGARDING INSURANCE

We will gladly bill your insurance company directly. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and Horizon Rehabilitation and Sports Medicine. ***It is ultimately your responsibility to see that your physical therapy bill is paid in full.*** Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER:

All co-pays and deductibles are due when services are rendered.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

MISSED APPOINTMENTS

Because we commonly have a waiting list, we request a call at least 24 hours in advance of missed appointments.

HIPAA

HIPAA NOTICE OF PRIVACY PRACTICES are available on file for your perusal.

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for **Horizon Rehabilitation & Sports Medicine** to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical and mental condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to **Horizon Rehabilitation & Sports Medicine**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

I have read and understand this ***Financial Policy***. I agree and acknowledge **Horizon Rehabilitation & Sports Medicine's** *HIPAA NOTICE OF PRIVACY PRACTICES,* Consent for Care & Treatment, and Benefit Assignment/Release of Information.

Patient/Guardian/Responsible Party____ Date_______________