HORIZON
REHABILITATION | SPORTS MEDICINE

NEW PATIENT INFORMATION FORM

(Please Print and write name how it is shown on your insurance card)

PATIENT INFORMATION

Patient's First name: MI: Last Name:			Date of Birth: / /
Social Security #:	❑ Male ❑ Female		Patient Nickname:
Street address:			
City:	State:	Zip:	Cell Phone no::
Occupation: Employer Name:	Email address:		Home Phone no:

Referred to clinic by (please check one box):
❑ Dr._____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Emergency Contact Name and no:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Insured's Name:	Insured's Name:
Insured's Birth Date:	Insured's Birth Date:
Insured's Gender:	Insured's Gender:
Relation to Insured:	Relation to Insured:

ACCIDENT DETAILS- PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY

Employment related: ❑ Yes ❑ No	Accident related: ❑ Auto ❑ Yes ❑ No	Date of first symptom or accident: / /

Give details of accident:

I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical benefits directly to this practice for the services rendered.

_____

Patient/Guardian signature Date

HORIZON
REHABILITATION | SPORTS MEDICINE

Cancellation & No Show Fee Policy

Due to high patient demand, and limited availability of appointments we have instituted a $50.00 no show/cancellation less than 24 hours fee.

Each time a patient misses an appointment without provided proper notice, another patient is potentially prevented from receiving care. As a result, we reserve the right to charge a $50.00 fee for these occurrences if you elect to either not show or cancel your appointment with less than 24 hours of notice.

In addition, if it is determined that you have habitually abused our attendance policy, you may be asked for payment of $85.00 in advance of your session to secure your appointment. This deposit will be refunded if you ultimately attend the scheduled appointment.

By signing this agreement, you the patient are attesting that you have been informed and understand our attendance policy. You are also attesting that you understand that this charge will be billed directly to you, not your insurance company.

_____

Patient Signature Date:

_____

Patient Name (Printed)

HORIZON
REHABILITATION | SPORTS MEDICINE

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.

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 WEARE 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.

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

CONSENTFORCARE& 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_____

HORIZON
REHABILITATION | SPORTS MEDICINE

Due to a recent change in MEDICARE PART B Benefits, it is necessary that we understand how much treatment you have received in an outpatient therapy, part B facility in the year of 2020.

This is ONLY for OUTPATIENT THERAPY that occurred in 2020.

Please sign the appropriate box below:

I have ***NOT*** received ***ANY*** outpatient, part B, Physical, Occupational or Speech Therapy Services in 2020.

Signature _____

I ***HAVE*** received approximately _____ visits of outpatient Physical, Occupational, or Speech Therapy Services in 2020.

I received these services at:_____

Signature: _____

Please Circle One of the following:

* I **AM** currently receiving home care services such as: Nursing, Social Services or Therapy.

* I am **NOT** currently receiving home care services such as: Nursing, Social Services or Therapy.

Signature: _____

If you have questions regarding this new Medicare ruling that is in effect for the remainder of 2020, please ask our front desk.

Thank you for your cooperation and helping us determine your available Medicare benefits.

HORIZON
REHABILITATION | SPORTS MEDICINE

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
__Increased pain at night __Fever/chills/sweats __Dizziness

HISTORY OF PRESENT INJURY

What part of your body is presently injured?_____

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 _____

HORIZON
REHABILITATION | SPORTS MEDICINE

Elder Abuse Suspicion Index – Mandatory for everyone over 65 years of age

Name: _____ Date: _____

Instructions: Please Circle your response to each question below:

Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No
Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	Yes	No
Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No
Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No
Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No

HORIZON
REHABILITATION | SPORTS MEDICINE

This Form Is Mandated To Be Completed By ALL PATIENTS

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
	TOTAL:			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

HORIZON
REHABILITATION | SPORTS MEDICINE

Current Medication/Supplement List (Required to be completed by all insurances)

Name: _____ Emergency Contact Name/Phone: _____

Date Last Updated: _____ _____ _____ _____

Prescription/OTC Medications and/or Supplements:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Other Notes

ACKNOWLEDGEMENT

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

Patient's Signature:_____ Date _____