WELCOME TO HUMAN PERFORMANCE AND REHABILITATION CENTER

Welcome to Human Performance and Rehabilitation Center. The following information will give you a better understanding of our payment and insurance filing policies.

PAYMENT POLICY: Payment is requested at the time of service unless other arrangements have been made prior to treatment. We accept cash, checks, Mastercard, Visa, or American Express.

INSURANCE: Human Performance and Rehabilitation Centers will file your primary insurance if you provide the appropriate insurance information. You will receive a statement each month if your account has a balance. You are responsible for payment of that balance. If your insurance does not pay, you should contact the insurance company. This office will not negotiate the settlement of a disputed insurance claim.

MANAGED CARE CONTRACTS: Horizons Diagnostics Physical Therapy is enrolled in numerous managed care and participating provider insurance programs. Please advise our staff if you are a member of this type of program. All co-pays or estimated patient balances are due at time of service. Our participation is not a guarantee of payment from your insurance. You will receive a statement for any balance after insurance. You will receive a statement for any balance after insurance has responded to our claim.

MEDICARE: The therapists at Human Performance and Rehabilitation Centers are participating Medicare providers. We will file your Medicare and one supplement if you provide us with the appropriate insurance information. You will receive a statement each month until your account is paid out. Pay only amounts in patient responsibility on your statement. Medicare will pay 80% of covered services after your deductible is met. You are responsible for your deductible and 20% of covered charges if your supplement does not pay timely. Medicare requires that you see your physician at least every 90 days while you are receiving therapy.

WORKERS COMPENSATION: Please provide Human Performance and Rehabilitation Centers with the proper information required to verify coverage. Except for acute cases, treatment will not begin until we have authorization from your worker's compensation carrier.

LEGAL CASES: We cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered.

IF YOU HAVE ANY QUESTIONS, SOMEONE FROM OUR BUSINESS OFFICE WILL BE GLAD TO ASSIST YOU.

CONSENT FOR TREATMENT & AUTHORIZATIONS: I do hereby consent for treatment at Human Performance and Rehabilitation Centers. I authorize Human Performance and Rehabilitation Centers to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to Human Performance and Rehabilitation Center when indicated on claim. I understand that I am financially responsible for the charges for services rendered.

Signed _____ Date _____

Relation to Patient _____

Witnessed by: _____

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PATIENT INFORMATION SHEET

Today's Date _____ Referring Doctor _____ Primary care provider _____
What part of the body are we treating? _____

PERSONAL INFORMATION

Name: First _____ Middle Initial _____ Last _____
Physical Address: _____ City _____ State _____
Mailing Address _____ City _____ State _____
Home phone (___) _____ Cell (__) _____ Work (___) _____
SS Number _____ DOB: ____/_____/____ Sex: M___F___
Marital Status: Married_____ Single _____ Email address: _____
Are you disabled? _____ if yes, what is your disability? _____
Employer _____ Occupation _____ Phone (___) _____
Spouse's name _____ DOB: _____ SS# _____
Spouse's Employer _____ Occupation _____ Work (___) _____
Emergency Contact (other than spouse) _____
Relationship _____ Home Phone (___) _____ Work (___) _____

INSURANCE INFORMATION

Primary Insurance _____ Name of Policy Holder _____
Policy No. _____ Policy Holder's Phone (___) _____
Policy Holder's DOB _____ Policy Holder's SSN _____
Policy Holder's Address (if different) _____

Secondary Insurance _____ Name of Policy Holder _____
Policy No. _____ Policy Holder's Phone (___) _____
Policy Holder's DOB _____ Policy Holder's SSN _____
Policy Holder's Address (if different) _____

If this is an approved claim through Worker's Compensation, please answer the following:

Date of Injury _____ Employer when injury occurred (if different) _____
W/C Insurance Name _____ Contact/Adjuster _____
Claim No. _____ Adjuster's Phone (___) _____

Please complete this section if the patient is a Minor and/or covered under parent's insurance

Mother's Name _____ Phone (____) _____ SSN _____
Address (if different) _____ Employer _____
Father's Name _____ Phone (___) _____ SSN _____
Address (if different) _____ Employer _____

Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy. We do check eligibility as a courtesy, but their failure to check could result in an unpaid bill for which you are responsible.

Signature: _____ Date: _____

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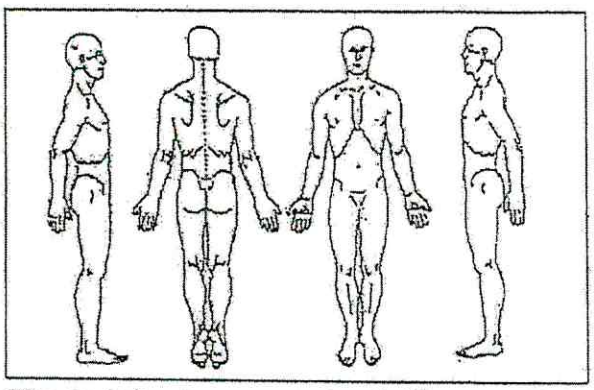
Name:	Date:	Gender:	Age:

CURRENT INJURY: _____

Please mark below where your pain is located



Please rate your current pain (0 = no pain)

0 1 2 3 4 5 6 7 8 9 10

Date started?
Describe the onset and history of current condition _____ _____
Occupation?
☐ Full Time ☐ Retired ☐ Not employed ☐ Part Time ☐ Disabled ☐ Modified ☐ Full or Part Time Student

SOCIAL HABITS:

Smoker/Tobacco Products?	Current/Past Usage per Day?	Year stopped?
Coffee? Y / N Drinks/week?	Alcohol? Y / N Drinks/week?	Soft Drinks? Y / N Drinks/week?
Current or Prior Exercise Program?		Frequency/Duration?

Please list your current medications, vitamins or supplements. *(If your medications are written down, please allow us to scan into your chart)* ***Please specify blood thinners and NSAID's***

_____

_____

_____

Please list any major surgeries (past 5 years) ***or pertinent to current condition***

_____

_____

_____

Please list any diagnostic tests you've had performed ***specific to current condition***

- ☐ Biopsy
- ☐ Blood work/Lab Tests
- ☐ Bone Density Scan
- ☐ CT Scan
- ☐ EEG
- ☐ EMG
- ☐ Lower GI Study
- ☐ Motility Study
- ☐ MRI
- ☐ Nerve Conduction Study
- ☐ Swallow Study
- ☐ Upper Endoscopy
- ☐ Ultrasound
- ☐ X-Ray
- ☐ Other

Over the past 6 months, have you been diagnosed with or are you currently experiencing any of the following symptoms?

◻ Osteoporosis	◻ High cholesterol	◻ Change in bowel habits
◻ Osteoarthritis	◻ High blood pressure	◻ Blood in stool or urine
◻ Rheumatoid arthritis	◻ Asthma	◻ Incontinence
◻ Dizziness	◻ COPD	◻ Low urine output
◻ Clumsiness or staggering	◻ Emphysema	◻ Urinary infection
◻ Double vision	◻ Palpitations	◻ Difficulty emptying bladder
◻ Falls to the ground	◻ Heart disease	◻ Kidney stones
◻ Anxiety	◻ Heart attack	◻ Painful intercourse
◻ Difficulty speaking	◻ Wheezing	◻ Sexually transmitted disease
◻ Fever or chills	◻ Coughing	◻ Numbness
◻ Night pain or sweats	◻ Difficulty swallowing	◻ Taste or smell change
◻ Muscle cramps	◻ Abdominal pain or fullness	◻ Skin turning yellow color
◻ Blood clots	◻ Constipation	◻ Rash/Itching or scaly patches
◻ Diabetes	◻ Diarrhea	◻ Hair or nail changes
◻ Open sores or wounds	◻ Heartburn	◻ Swelling in the arms or legs
◻ Dark red/purplish legs	◻ Antacid use	◻ Liver or gallbladder issues
◻ Fibromyalgia	◻ Vomiting	◻ Thyroid problems
◻ Fatigue	◻ Nausea	◻ TB ◻ Current ◻ Past
◻ Sleep apnea or snoring	◻ Appetite or weight change	◻ Allergies

Have you had any of the following procedures?

◻ Bypass Surgery ◻ Pacemaker ◻ Joint Replacement
◻ Cardiac Ablation ◻ Stent Placement ◻ Metal Implants

Females

◻ Currently Pregnant ◻ Regular Menstrual Cycle ◻ Menopausal Symptoms

Living Situation

◻ Single Story Home ◻ Ground Floor Apartment ◻ Assisted Living Facility
◻ 2 Story Home ◻ Upper Level Apartment ◻ Skilled Nursing Facility
◻ Yes ◻ No Are there stairs at home? ◻ Yes ◻ No Is there a handrail present?
◻ Other situation

Who do you live with?

◻ Spouse ◻ Child(ren) ◻ Alone
◻ Spouse + Children ◻ Other Family Member ◻ Other
◻ Yes ◻ No Are others available to help if needed?

What is your primary role at home?

◻ Caregiver for others ◻ Housework ◻ Yard Maintenance
◻ Financial Provider ◻ Home Maintenance ◻ Other
◻ Yes ◻ No Is the patient currently able to perform these roles?

ACKNOWLEDGEMENT OF NOTICE OF INFORMATION PRACTICES

(To be retained by Medical Provider)

I understand that Human Performance and Rehabilitation Center (referred to below as "the clinic") will use and disclose health information about me while providing treatment.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult and coordinate with other health care providers in the course of my treatment
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support he clinic's ability to provide me with appropriate care and arrange for payment.

I also understand that I have the right to receive a written Notice of Information Practices that describes how the clinic uses and discloses health information, the information practices followed by the clinic staff and my rights regarding my health information.

I understand that the Notice of Information Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Information Practices upon request. I also understand that a copy of a summary of the most current version of the clinic's Notice of Information Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Information Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I will be provided with a copy of the Notice of Information Practices upon request.

By: _____ Date _____

(Patient)

-OR-

By: _____ Date _____

(Patient's Representative)

Description of Representative's Authority _____

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Missed Appointment Agreement

HPRC cares about the health and well-being of the patients we serve.

Consistent attendance is important to maximize our patients progress. We understand sometimes circumstances occur that prevent the patient from coming to therapy. When that happens, it is important you let us know that you will be unable to attend the scheduled session.

No shows: When a patient does not show or misses their appointment, they will be subject to a $30 fee that will be billed directly to the patient.

Timely Cancelations: If you need to cancel or reschedule your you appointment, we ask that you give us at least 24 hours notice. Cancellations made with less than 24 hours' notice may be considered "no show" and a $30 fee may be added to your account.

On Time Arrivals: We ask that you notify us in advance if you're going to be more than 10 minutes late for your appointment. Failure to do so may result in a $30 no-show fee being added to your account.

This procedure has been put in place to limit the number of "no shows" so that we can provide high-quality therapy services to all patients. Thank you for your understanding and cooperation.

_____

Print name

_____

Signature

_____

Date