HORIZON PHYSICAL THERAPY
9154 ESTATE THOMAS
ST. THOMAS V.I 00802
(340)776-7667 P
(340)714-1891 F

WELCOME

We are pleased you have chosen us for your physical therapy needs. Our office is committed to providing you with the best possible experience and highest quality of care. We are here to help you in any way possible.

We will bill directly to Workmen's Compensation, Veteran Administration, Vocational Rehabilitation, and other major insurance companies such as BC/BS of the Virgin Island, Cigna, United Health Care, Canada Life and Atlantic Southern. Major insurance companies may cover up to 80% of charges but **you** are required to pay for any amount that the insurance company may not pay.

YOU ARE RESPONSIBLE FOR PAYMENT OF OUR SERVICES. IF YOUR INSURANCE COMPANY DOES NOT PAY FOR ANY REASON OR TAKES LONGER THAN 90 DAYS, YOU MAY BE REQUIRED TO PAY AND COLLECT FROM THEM YOURSELF. WE CHARGE THE 9% INTREST ALLOWED BY VIRGIN ISLANDS LAW ON ANY UNPAID AMOUNT AFTER 90 DAYS.

We DO NOT bill attorneys or accept liens. If you have any difficulties with our policies, please arrange to discuss the matter with the Facility Director.

THANK YOU FOR CHOOSING HORIZON PHYSICAL THERAPY

****

Name_____ Age_____ DOB_____

Physical Address _____ Phone_____

Mailing Address_____ Alt. Phone_____

Zip Code _____ Social Security Number _____

EMPLOYMENT STATUS

Employer _____ Occupation_____

Employer's Number _____

HOW WILL YOU PAY FOR YOUR SERVICES?

Primary Insurance _____ Patient Name_____

Subscriber's Name_____ Subscriber SSN_____

Subscriber's DOB_____ Subscriber's Place of Employment _____
Did you meet your Deductible?_____ What is your Copay?_____

IT IS VERY IMPORTANT THAT YOU COMPLETE THE FOLLOWING INFORMATION:

What is your doctor's name? _____

What is your doctor's number? _____

Location/ type of pain and/ or limitations._____
_____

Did you have an injury? **Y N** If yes:
Was it work related? **Y N**
Was it due to a motor vehicle accident? **Y N**
What was the date of the injury? _____
Has any other doctor, physical therapist or other medical professional treated you for this problem before? **Y N**
If yes, who treated you, when were you treated and what did they do for treatment _____
_____
_____

Your medical history (circle all that apply):

Diabetes	Asthma
Hypertension/ High Blood Pressure	Emphysema/ COPD
Heart Disease _____	Cancer (type) _____
Sickle cell anemia	Peripheral vascular disease

Other:_____
_____
Please list any operations you have had _____
_____
Please list all medication that you take _____
_____

Non – Medical History
Marital status: unmarried married separated divorced other
Do you work outside the home? If so, what type of work? _____
Please list all activities and sports you participate in._____
_____
Do you use tobacco products? **Y N if** yes please indicate which of the following apply
Cigarettes_____pack(s) per day, for _____ years
Cigars _____daily/ weekly/monthly, for_____years
Dip/ chew/ other
Do you drink alcoholic beverages? **Y N If** yes
Approximate frequency: _____ drinks per day/weekly/monthly
Are your right**- handed** or **left- handed** (circle one)

Your height: _____ Weight: _____

Questions regarding your general health; please circle any symptoms or conditions which you are currently experiencing or have recently experienced:

Weight loss	tingling in the hand or feet	Urinary problems
Weight gain	Skin sores	Allergies
Fever	Changes in eye sight	Weakness
Headache	Shortness of breath	Heartburn
Palpitations	Unusual bleeding	Chest pain
Menstrual problem		

Are you currently pregnant? **Y N**

I CERTIFY THAT THE INFORMATION PROVIDED ABOVE IS CORRECT AND ACCEPT MY FINANCIAL RESPONSIBILITIES AS DEFINED ABOVE. FURTHER MORE, I CONSENT TO RECEIVE TREATMENT AT HORIZON PHYSICAL THERAPY AND PERMIT ITS EMPLOYEES AND ALL OTHER PERSONS CARING FOR ME IN WAYS THEY JUDGE BENEFICAL TO ME. I UNDERSTAND THAT THIS CARE CAN INCLUDE EVALUATION, TESTING AND TREATMENT AND NO GUARANTEES HAVE BEEN MADE TO ME ABOUT THE OUTCOME OF THIS CARE.

Patient's Signature_____ Date_____

The patient's signature certifies that he/she has read the above.

I HEREBY AUTHORIZE HORIZON PHYSICAL THERAPY TO RELEASE ANY/ ALL INFORMATION REGARDING MY MEDICAL HISTORY, TREATMENT, SYMPTOMS EXAMINATION, RESULTS OR DIAGNOSIS TO ANY PERTINENT INSURANCE COMPANIES, PHYSICIANS, OR ANY OTHER RESPONSIBLE PARTIES.

Patient's Signature_____ Date_____

The patient's signature certifies that he/she has read the above.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY ELIGIBILTY FOR BENEFITS WITH MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE COST OF SERVICES RENDERED AT HORIZON PHYSICAL THERAPY IF MY INSURANCE DOES NOT PAY.

Patient's Signature_____ Date_____

The patient's signature certifies that he/she has read the above.

NOTICE OF PRIVACY PRACTICES
HORIZION PHYSICAL THERAPY
ABBREVIATED VERSION

THIS NOTICE DESCRIBED HOW MEDICAL INFORMATION ABOUT YOU WILL BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Horizon Physical Therapy is required by law, to maintain the privacy an confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. This is an abbreviated notice, but the full notice is available for your review if you desire.

Disclosure of Your Health Information

Treatment
We may disclose your health care professionals within our practice for the purpose of treatment payment or health care operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with the State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or event of an emergency or of your death.

Complaints
Complaints about your privacy right or how Horizon Physical Therapy has handled your health information should be directed to Jennifer Payne, PT.

This notice is effective as of 04/14/03

I have read this abbreviated Notice of Privacy Practices and understand my rights contained in this notice.

By way of my signature, I provided Horizon Physical Therapy wit my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as described in the notice of Privacy Practices.

_____
Patients Name (print)

_____ _____
Signature of patient Date

_____ _____
Authorized Facility Signature Date