Patient Name _____

Date _____

FYZICAL®
Therapy & Balance Centers

Client Needs Screen (CNS)

1.	Have you had a fall in the past year?	☐ Yes	☐ No
2.	Do you have a fear of falling?	☐ Yes	☐ No
3.	Would you like your balance to be assessed?	☐ Yes	☐ No
4.	Do you experience dizziness or imbalance?	☐ Yes	☐ No
5.	Do you lose your balance when stepping up/down curbs or stairs/steps?	☐ Yes	☐ No
6.	Do you have a difficult time walking in the dark?	☐ Yes	☐ No
7.	Do you have difficulty hearing?	☐ Yes	☐ No

8.	Do you have osteoporosis, osteoarthritis and/or joint pain?	☐ Yes	☐ No
9.	Do you take bone and/or joint supplements?	☐ Yes	☐ No
10.	Do you experience muscle aches, pains and/or muscle cramping?	☐ Yes	☐ No
11.	Do you use cold, heat or compression therapy at home?	☐ Yes	☐ No
12.	Are you interested in learning how compression clothing with ice could help your condition?	☐ Yes	☐ No
13.	Are you interested in learning how home heat and/or cold therapy could help your condition?	☐ Yes	☐ No

14.	Do you have foot and/or ankle pain/discomfort?	☐ Yes	☐ No
15.	Do you currently wear shoe inserts?	☐ Yes	☐ No
16.	Are you interested in learning about how a shoe insert could help with your condition?	☐ Yes	☐ No
17.	Do you have pain and/or physical challenges other that what you are being seen for today?	☐ Yes	☐ No
18.	Would you like to get more information about your whole-body health?	☐ Yes	☐ No
19.	Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	☐ Yes	☐ No

Patient Name _____

Date _____

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Patient Name _____

Date _____

Date of Injury/Onset _____ Date of next physician's visit _____

Have you ever had these symptoms before? Yes No Height_____

Email: _____ Weight_____

Circle all that apply to your symptoms:

Work related injury, State Occurred _____ Athletic or recreational injury Cause unknown

Motor vehicle accident, State Occurred _____ Injury related to lifting Other

Have you had a related surgery? Yes No When: _____

Are you presently working? Yes No Occupation _____

Do you participate in any sport, activities, or exercise program on a regular basis? Yes No

Do you currently have or have a past history of any of the following? (Please Circle)

Heart Attack	Yes	No	Hernia	Yes	No
Heart Disease	Yes	No	Cancer	Yes	No
Heart Palpitations	Yes	No	Bowel/bladder abnormalities	Yes	No
Chest Pain/Angina	Yes	No	Liver/gallbladder problems	Yes	No
High Blood Pressure	Yes	No	Hepatitis	Yes	No
Are you on blood thinners?	Yes	No	Thyroid condition	Yes	No
Do you have a pacemaker?	Yes	No	Kidney Problems	Yes	No
Stroke	Yes	No	Allergies to heat	Yes	No
Diabetes	Yes	No	Allergies to cold	Yes	No
Type 1 juvenile	Yes	No	Other allergies	Yes	No
Type 2 adult onset	Yes	No	Metal implants	Yes	No
Do you take insulin?	Yes	No	Recent fractures	Yes	No
Hypoglycemia	Yes	No	Recent surgery	Yes	No
Asthma/difficulty breathing	Yes	No	Skin abnormalities	Yes	No
Do you use an inhaler?	Yes	No	Fibromyalgia	Yes	No
Are you pregnant?	Yes	No	Rheumatoid arthritis	Yes	No
Do you smoke?	Yes	No	Osteoarthritis	Yes	No
Headaches	Yes	No	Sexual dysfunction	Yes	No
Dizziness/Fainting	Yes	No	Other STD/HIV	Yes	No
Ringing in your ears	Yes	No	Tuberculosis	Yes	No
Nausea/Vomiting	Yes	No	Osteoporosis/Osteopenia	Yes	No
Seizures	Yes	No	Other	Yes	No

If you answered **YES** to any of the previous questions – please explain and give approximate date:

_____

_____

_____

_____

_____

Patient Name _____

Date _____

Is there any other information about your past medical history that we should know?

_____

_____

_____

_____

_____

Are you taking any medications? (over-the-counter and prescribed Yes No

If so, please list below or provide a list.

Medication Name	Dosage	Frequency	Route(oral/topical/etc)

Circle the intensity of your pain on a scale of 0 to 10. With 0 being no pain and 10 being the worst

Worst?	0	1	2	3	4	5	6	7	8	9	10
Current?	0	1	2	3	4	5	6	7	8	9	10
Best?	0	1	2	3	4	5	6	7	8	9	10

Please show us where your pain is on the illustration

What Describes Your Pain?

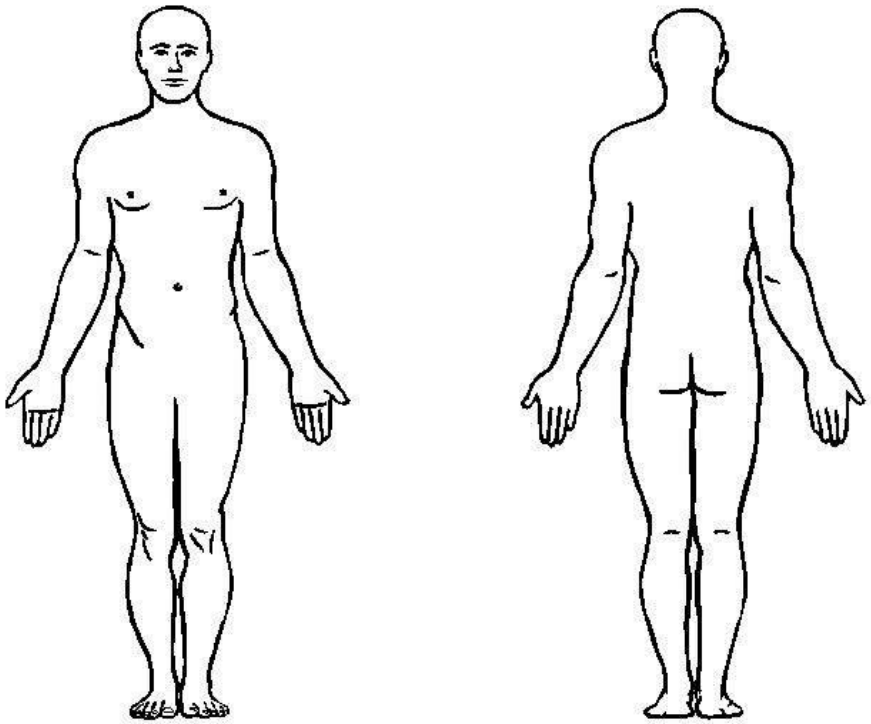
(Please circle)

Dull/Achy

Sharp

Numb/Tingling

Other _____



Patient Name _____

Date _____

Emergency and Additional Contact Information

Name: _____	Phone Number: (_____) _____	Relationship to Patient _____
Account Responsible on Insurance: ___Patient ___Other Person	If Other Person, their name: _____	If Other Person their date of birth/ssn: _____

Employer Information

Name of Employer: _____	Address:
Are you or the account responsible insured through an employer? ___Yes ___No	Phone Number: _____

Patient Financial Policy

Please read the financial policies, initial where applicable and sign and date at the bottom.

I understand that it is the policy of Southwest Orthopaedic Physical Therapy to collect the estimated patient responsibility obtained from my insurance company on each date of service as well as the balance on my account. This balance may be due to but is not limited to co-pay/co-insurance, deductible or non-covered services. SWOPT will estimate the co-insurance percentages based on what insurance is expected to pay. Because this is an estimate and not an exact figure, there is a possibility that I will still be responsible for an additional balance and or that I may be due a credit refund if I have overpaid. _____*Inital*

You are required to present a valid insurance card at your visit and to inform our office **immediately** of any insurance or doctor changes. Any denial of payments as a result of failure to report changes to our office becomes patient responsibility. _____*Inital*

I authorize my insurance company to make payment to Southwest Orthopaedic Physical Therapy for services rendered to me or my dependant. _____*Inital*

I understand that it is ultimately my responsibility to review my explanations of benefits that I receive. Many times services are not covered due to your individual insurance plan and I agree to inform SWOPT if I wish to not continue these services. _____*Inital*

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. If an insurance company has not paid within 90 days of billing, fees are due and payable in full from you.

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover from Medicare. If your secondary insurance does not pay within 60 days of billing, fees are due and payable in full from you. Any outstanding balances are due prior to your appointments.

Auto Insurance: Our office accepts most auto insurance for payment of service. We have no way of knowing how much medpay you have or has been accrued. Once medpay has been exhausted all balances become your responsibility.

Patient Name _____

Date _____

Our office requires a 24-hour notice for any cancelled appointments. If 24-hour notice is not given, you do not show up, or you arrive 15 or more minutes late for a scheduled appointment, a **$50 No Show Fee** will be assessed. We reserve the right to cancel all future appointments after 3 missed appointments. _____*Inital*

If balances are not paid according to the terms, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay all additional fees in the collection of the debt. _____*Inital*

I understand that my individual insurance plan may or may not cover some or all the services provided. I understand that I will be ultimately responsible for any balances on my account. _____*Inital*

If an attorney is hired at any point during treatment I understand I must notify this office immediately and provide a letter of protection from my attorney _____*Inital*

Consent to treat

I hereby give written consent to be treated at SWOPT by a licensed physical or occupational therapist, physical therapy student, physical therapy assistant, pt tech or aide, massage therapist, and or myofascial trigger point therapist. _____*Inital*

Authorization to release medical information

I hereby authorize the release of my medical and billing records to any healthcare provider involved in my care and treatment. SWOPT may also release information to any person or organization liable for all or part of my charges, such as my insurance carrier, my adjuster, my insurance claim department, any 3rd party payor, medicare/medicaid, my employers workers compensation carrier, my attorney. I acknowledge that upon the disclosure of medical record information to an insurance company or payor pursuant to this authorization, SWOPT is no longer responsible for the confidentiality of any information know or possessed by the payor. _____*Inital*

HIPAA

My signature below indicates that I have been given the Notice of Privacy Practices for FYZICAL Therapy & Balance Centers. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to FYZICAL Therapy & Balance Centers to release any of my protected healthcare information.

_____*Inital*

Consent for Photography/Videotaping

I hereby give my consent to have photographs, videotaped images, or other images made of myself to be put in my personal medical file.

_____I Give Consent for Photography/Videotaping

_____I Do Not Give Consent for Photography/Videotaping

I have read and understand the above information.

Patient/guardian signature_____**Date**_____

Patient Name _____

Date _____

ATTENTION TO OUR PATIENTS

- AS A REMINDER, OUR FRONT OFFICE COLLECTS COPAYS, COINSURANCE AND PAYMENT TOWARDS DEDUCTIBLES OR NON-COVERED ITEMS/SERVICES AT TIME OF SERVICE.

- WE DO NOT KNOW **EXACT** AMOUNTS DUE UNTIL YOUR CLIAMS ARE PROCESSED BY YOUR INSURANCE COMPANY.

- JUST BECAUSE WE COLLECT A CERTAIN AMOUNT AT TIME OF SERVICE, IT IS IMPORTANT THAT YOU ACKNOWLEDGE THAT IT IS AN **ESTIMATE** AND THAT THERE MAY BE A **BALANCE** DUE OR IF YOU HAVE OVERPAID THERE WILL BE A **CREDIT** ON YOUR ACCOUNT WHICH WILL BE APPLIED TO BALANCES OR REFUNDED AT A LATER DATE.

EXAMPLES OF DIFFERENT SCENARIOS:

- COPAYS: IF WE COLLECT A $40.00 COPAY AT TIME OF VISIT BUT YOUR INSURANCE ASSESSED A $50.00 COPAY, YOU WILL BE RESPONSIBLE FOR THE ADDITIONAL AMOUNT DUE. IF THE ADDITIONAL AMOUNT IS NOT COLLECTED AT TIME OF SERVICE, YOU WILL BE BILLED FOR OUTSTANDING BALANCES. IF YOU HAVE OVERPAID FOR A DATE OF SERVICE, THE CREDIT MAY BE APPLIED TO BALANCES ON YOUR ACCOUNT FOR OTHER DATES OF SERVICE OR REFUNDED AT A LATER DATE.

- COINSURANCE: THESE ARE ESTIMATES BASED ON YOUR PERCENTAGE OF COINSURANCE. IF WE WERE QUOTED YOU WOULD HAVE A 10% COINSURANCE WE COLLECT $10, IF 20% WE COLLECT $20, IF 30% WE COLLECT $30, ETC. THESE **ARE NOT** EXACT FIGURES BECAUSE WE DO NOT KNOW THE EXACT AMOUNT TO BE BILLED TO INSURANCE COMPANY AS TREATMENTS MAY VARY FROM DAY TO DAY AND WE ALSO DO NOT KNOW HOW YOUR CLAIM WILL BE PROCESSED BY YOUR INSURANCE. IF YOU HAVE UNDERPAID FOR A DATE OF SERVICE, YOU WILL BE BILLED FOR THE REMAINDER. IF YOU HAD OVERPAID FOR A DATE OF SERVICE, THE CREDIT MAY BE APPLIED TO BALANCES ON YOUR ACCOUNT FOR OTHER DATES OF SERVICE OR REFUNDED AT A LATER DATE.

- DEDUCTIBLES: DEDUCTIBLE AMOUNTS VERY SO WE COLLECT $100/VISIT UNTIL WE ANTICIPATE THE DUCTABLE WILL BE MET. FOR EXAMPLE, IF YOU HAVE A $500 DEDUCTIBLE, WE WILL COLLECT $100 FOR FIVE (5) VISITS. THIS DOES NOT MEAN THAT IS ALL THAT WILL BE OWED. ONCE AGAIN, WE WILL NOT KNOW TRUE BALANCES DUE UNTIL YOUR CLAIMS ARE PROCESSED BY YOUR INSURANCE. IF YOUR INSURANCE ASSESSES A LARGER ABOUT TOWARDS YOUR DEDUCTIBLE FOR A DATE OF SERVICE YOU WILL BE RESPONSIBLE FOR THE ADDITIONAL BALANCE DUE. IF YOU HAVE OVERPAID BASED ON WHAT YOUR INSURANCE ASSESSES, YOUR CREDIT WILL BE APPLIED TO OTHER BALANCES DUE OR REFUNDED AT A LATER DATE.

ONCE AGAIN WHAT IS COLLECTED IS AN ESTIMATE AND YOU MAY DO MORE THAN WHAT WAS COLLECTED OR YOU MAY HAVE A CREDIT ON YOUR ACCOUNT IF BUT WE COLLECTED WAS MORE THAN WHAT INSURANCE TO PUT TOWARDS A PATIENT RESPONSIBILITY.

I ACKNOWLEDGE THAT I HAVE READ AND AM AWARE THAT I MAY ULTIMATELY BE RESPONSIBLE FOR ADDITIONAL AMOUNTS DUE ON MY ACCOUNT REGARDLESS OF WHAT WAS COLLECTED AT THE TIME OF VISIT:

Patient/guardian signature_____**Date**_____