FYZICAL®
Therapy & Balance Centers

Barkley Medical Center
2075 Barkley Blvd. Suite 200
Bellingham WA 98226

T: 360.733.4008
F: 360.733.4064

Thank you for contacting FYZICAL Therapy & Balance Centers and visiting our website.

As we talked on the phone, included is the paperwork that you may complete before you come in for your appointment. This will assist in starting your appointment on time with your Physical Therapist.

- Patient Registration sheet – Please complete and sign. Additionally, we need to scan a copy of your current insurance card(s), so please bring that with you.

- Medical History Form – Complete this form. Please mark on the diagram at the right, which area of your body we will be working on. If you are a Medicare patient, Medicare requires us to have a complete listing of your medications on file, with the details indicated. If you would like to bring a separate list of those details, we can scan it into your record. **Thank you for the time it will take to fill this out.**

If you have any questions, please feel free to call our office at 360-733-4008 or simply wait and ask your questions at your appointment.

Thanks once again for completing your paperwork ahead of time. We look forward to seeing you soon.

Sincerely,

Reception Staff

FYZICAL Therapy & Balance Centers

Patient Name_____ Date of Birth___/___/___ Gender M F

Email Address: _____ **Social Security #** _____

REASON FOR VISIT/Area of body to be treated: _____Date of onset: ___/___/___ Date of surgery: ___/___/___

Primary Insurance: _____ Secondary Insurance: _____

Primary Physician: _____ **Referring Physician**: _____

Are you receiving Home Health Care? *Yes No*

Have you been seen in another Physical Therapy office this last year? *Yes No* If yes, when? _____where? _____

Accident Information Date of injury____/____/____

Were you involved in a Motor Vehicle Accident? **Yes No** Were you involved in a Work related Injury? **Yes No**

Please fill out reverse side

Appointment Reminders: Our office will print you a list of your scheduled appointments.
In addition, you may choose to receive a reminder, 24 hours prior to your appointment, by text message or by email.
*Please choose **ONE**:*

- ☐ Text message reminder to my cell phone: _____ My cell phone **carrier** is : _____
- ☐ Email reminder to this email address:_____
- ☐ I am not interested in text/email Reminders. My schedule printout will be my reminder for my appts.

Parent (if minor/college student)/Responsible Party Name: _____Date of birth ___/___/___

Address: _____ Phone(___)_____
Street City State Zip

Consent to Treat and Authorization to Bill Insurance

I consent to treatments and authorize use of this signature for the release of medical information necessary to process all claims with my insurance company. FYZICAL Therapy & Balance Centers will bill my insurance company directly and I authorize direct payment of benefits to FYZICAL. I understand it is my responsibility to know my healthcare benefits, its limits and non-covered items. I also will obtain a referral, if required by my insurance. I am aware that any visits denied or not covered due to "no referral" are my responsibility. I will keep FYZICAL Therapy & Balance Centers informed of any changes to my insurance coverage. I will be personally responsible for any copays, deductible, or non-covered balances remaining after insurance consideration. I understand that my insurance requires that copays are made at the time of each visit.

If I choose to receive Appointment Reminders by text messaging, normal text messaging rates may apply.
I also understand that any email communication that I may agree to receive is not sent in an encrypted format.

_____Date: _____
Signature of Patient or responsible party (if patient is a minor)

"NOTICE OF PRIVACY PRACTICES"

Law requires us to make a good faith effort to obtain your signature signifying you have been offered a copy of our Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. The Notice provides a description of our treatment, payment, healthcare operations, and the uses and disclosures we may make of your Protected Health Information. It explains in detail the procedures we use to protect your healthcare and personal information. Please take the time to read it carefully and completely.

"By my signature below I acknowledge receipt of the Notice of Privacy Practices. I also understand that I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations."

_____ _____
Patient or legally authorized individual signature Date

ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT

Date of injury: ___/___/___ Were you a pedestrian? _____

In Washington State? Yes No If No, where? _____

Your PIP Insurance Company:_____

Do you have PIP coverage under your Policy?

If so, what are your PIP Policy Limits? $10,000 or $30,000

Your PIP Claim#:_____

Your PIP Claim Adjuster:_____Phone_____

Other Party's Insurance Company _____ Claim #:_____

If you have consulted an attorney, please provide:

Attorney Name:_____

Phone #: _____

WORK RELATED INJURY

Exact Date of injury: ___/___/___

Who was your Employer at the time of injury:_____

Have you received previous Physical Therapy for this claim?

Yes No If yes, where? _____

Washington State L&I Claim #: _____

If self-insured Workman's Comp, please provide:

Name of Insurance Company: _____

Claim Manager: _____

Claim Manager's Phone#: _____

Claim #: _____

MEDICAL HISTORY FORM FYZICAL Therapy & Balance Centers

Please check if you have, or have had, any of the conditions listed below:

Allergies	Yes ☐ No ☐	Depression	Yes ☐ No ☐	Multiple sclerosis	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Anxiety	Yes ☐ No ☐	Dizzy spells	Yes ☐ No ☐	Parkinson's	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Emphysema/Bronchitis	Yes ☐ No ☐	Rheumatoid arthritis	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Fractures	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Gallbladder problems	Yes ☐ No ☐	Speech problems	Yes ☐ No ☐
Cardiac Conditions	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐	Strokes	Yes ☐ No ☐
Cardiac Pacemaker	Yes ☐ No ☐	High blood pressure	Yes ☐ No ☐	Thyroid disease	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	Incontinence	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Circulation Problems	Yes ☐ No ☐	Kidney problems	Yes ☐ No ☐	Vision problems	Yes ☐ No ☐
Currently Pregnant	Yes ☐ No ☐	Metal Implants	Yes ☐ No ☐		

Describe any other conditions or precautions:_____

_____

Fall History:

Have you sought medical attention as a result of a fall in the past year? Yes ☐ No ☐

Have you had two or more falls in the past year? Yes ☐ No ☐

Surgical History:

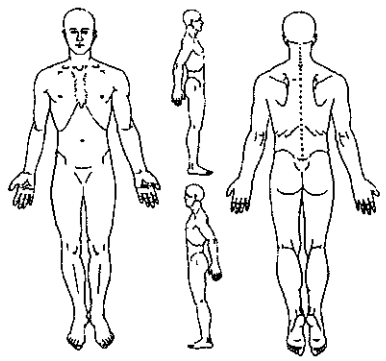
List past surgeries, and approximate dates of surgeries:

_____

_____

_____

_____



Please mark on the diagram the location of your pain.

Current Medications (including prescriptions, over-the-counter meds, Vitamins, Supplements):

Medication name	*Dosage*	*Frequency*	*How do you take it?*
			By mouth ☐ Injection☐ Other : _____
			By mouth ☐ Injection☐ Other : _____
			By mouth ☐ Injection☐ Other : _____
			By mouth ☐ Injection☐ Other : _____
			By mouth ☐ Injection☐ Other : _____
			By mouth ☐ Injection☐ Other : _____

Please attach a sheet if more room is needed.

Do you have a follow up appointment scheduled with the Doctor who referred you to our clinic? Yes ☐ No ☐

If so, when? _____

Completed by: _____ Signature_____ Date_____

(Printed name) (Patient's signature)

Initials _____Date_____ Initials _____Date_____ Initials _____Date_____ Initials _____Date_____ Initials _____Date_____ Initials _____Date_____