CLIENT INFORMATION

Last Name:_____First Name:_____Middle Initial:_____
Address:_____Apt:_____
City:_____State:_____Zip:_____
Date of Birth:_____Sex:_____Social Security#:_____
Home Phone#:_____Cell#:_____E-Mail_____
Preferred Contact Method: PHONE ☐ EMAIL ☐ TEXT ☐
Emergency Contact:_____Phone#:_____Relationship:_____
Primary Doctor:_____Referring Doctor:_____
Have you had any Home Health in the past 12 Months: YES ☐ NO ☐ If yes, Company:_____
Have you had any physical, occupational, or speech therapy this year? YES ☐ NO ☐
How did you hear about FYZICAL?_____

Insurance Information

Medicare #_____ Part B effective date_____
Insurance Policy #_____Group #:_____
Policyholder's Name: _____Relation to Patient:_____DOB:_____
Insurance Address (if other than above):_____

IF CLIENT IS A MINOR/ ALTERNATIVE PARTY RESPONSIBLE

Responsible party for bill if other than client: _____ Relationship:_____
Responsible party's address (If different than above): _____
Date of Birth:_____ Social Security: _____

Consent for Treatment:

I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information:

I authorize FYZICAL to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and

Consent to Obtain Medical Information:

I authorize FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, CAT scans, and MRI reports, along with Physician's documentation.

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to FYZICAL

Guarantee of Payment:

I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

Cancellation No show policy:

I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and effects other patients as well. Appointments without sufficient notice (Less than 24 hours) or a no-show without any notice will be charged a $50 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as a patient.

I hereby certify that I understand these rights as set forth

I acknowledge that I have been informed of FYZICAL's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information.

I have received a copy of the patient's rights and responsibilities handout: YES ☐ NO ☐

Client/Responsible Party Signature: _____Date:_____

Legal Representation (If applicable): Name:_____Signature:_____