Patient Consent & Financial Agreement

Authorization for Treatment

Physical therapy services offered at FYZICAL includes, but not limited to evaluation techniques, soft tissue techniques, manual therapy techniques, heat, cold, electrical stimulation, electrical modalities, paraffin, stretching activities, strengthening exercises, cervical/lumbar traction, and the use of gym and/or other fitness equipment.

I have been informed that if any soft tissue technique, particularly Graston technique / active release/ cross-fiber friction mobilization, are used, it may cause bruising and tenderness in the region that is/was treated. If the technique is too uncomfortable, I will bring it to the attention of my physical therapist so that the procedure can be modified or ceased.

I understand that I have the right to refuse any physical therapy service(s) offered if I so choose. I understand that physical therapy may involve some risk and I hereby release FYZICAL from liability now or in the future.

Assignment of Insurance Benefits and Release of Information

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits; insurance payments be made to FYZICAL and its affiliates. I authorize payment of medical benefits to FYZICAL and its affiliates.

Personal Valuables/Dependents/Visitors

It is understood and agreed that FYZICAL is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, if children are present, please keep them off the exercise equipment in order to prevent injuries.

Financial Agreement

I, the undersigned agree, to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that FYZICAL and its affiliates bill insurance companies as a courtesy. I understand that all co-payments, coinsurance, and deductibles are due at the time of service. I understand that benefits quoted to me are only an estimate. I understand that it is my responsibility to know and understand my health plan. I understand that FYZICAL is not responsible for any inaccurate information they receive from my insurance. I understand that it is my responsibility to obtain necessary referrals from my doctor prior to coming to FYZICAL. Should my account be referred to an agency or attorney for collections, I may be responsible for any and all attorney and collection fees charged to FYZICAL associated with collecting the debt. **I agree to pay an insufficient funds fee for any returned checks.**

Credit Card/Debit Card Payments by signing this form I authorize FYZICAL and its affiliates to keep my credit card on file for future payments. I will be required to sign each receipt approving the charge. You have the option to decline this convenience and physically produce your card at every visit. If you would like to decline this option please initial here ______

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As indicated in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you are stating that you have reviewed the Notice of Privacy Practice and do not want a paper copy at this time. You may request a copy of the Notice and/or ask any questions about the Notice at any time.

My signature below is acknowledging the above consent and agreeing to the terms in its entirety.

____ ______/______/______

Patient or Legal Guardian's Signature Date

FYZICAL Therapy & Balance Centers

Patient Registration Form (Formulario de registro de pacientes)

By accurately filling out this form in its entirety and with legible handwriting we will have better success in billing a clean claim to your insurance company. (Al rellenar con precisión este formulario en su totalidad y con la escritura legible, tendremos mejor éxito en la facturación de una reclamación limpia a su compañía de seguros.)

Patient Information Información del paciente

Last Name (Apellido)	**First Name** (Nombre)	**Middle** (Segundo)
Mailing Address (Dirección)		**Apt/Condo#** (Apartamento#)
City (Ciudad)	**State** (Estado)	**Zip** (Código postal)
Home Phone (Telefono)	**Cell Phone** (Telefono Cellular)	**Email** (Correo Electronico)
Approved method of contact for appointment reminders and other electronically generated messages. Circle all that apply Método de contacto aprobado para recordatorios de citas y otros mensajes generados electrónicamente. Círculo de todos los que se aplican **Text** (Texto) Voice (Voce) Email (Correo Electronico)		
Date of Birth (Fecha de Nacimiento) M D Y_	**Gender** (Género) Female (Mujer) Male (Hombre)	**Social Security Number** (Número de Seguro Social)
Marital Status (Estado civil) Single Married Widowed Other	**Employer's Name** (Empleador)	**Occupation** (Ocupacion)
Emergency Contact Person (Nombre de Contacto de emergencia)	**Emergency Contact Phone#** (Telefono de emergencia)	**Relationship to Patient:** (Relacion con el paciente)
Related cause to why you are being seen in our office (Causa relacionada por la que lo están viendo en nuestra oficina) Work Injury Auto Accident Surgery Other		**Injury Date or Surgery Date:** (Fecha de lesion o cirugia) / /
Referring Physician or Name of Primary Care Physician	**Name of Practice Group**	**Date of Last Visit with Physician** / /
Insurance Name #1	**Policy/ID Number**	**Group Number**
Insurance Name #2	**Policy/ID Number**	**Group Number**

Spouse and or Guardian Information Información del cónyuge or tutor

Last Name (Apellido)	**First Name** (Nombre)	**Date of Birth** (Fecha de Nacimiento) M D Y
Social Security Number (Número de Seguro Social)	**Relationship to Patient:** (Relacion con el paciente)	**Employer's Name** (Empleador)

Is the patient is receiving home health services currently? YES NO
(¿El paciente recibe actualmente servicios de salud en el hogar?)

Has the patient received home health services in the past 30 days? YES NO
¿Ha recibido el paciente servicios de salud en el hogar en los últimos 30 días?

Are you receiving physical therapy services elsewhere? (Even for a non-related diagnosis). YES NO
¿Recibe servicios de fisioterapia en otro lugar?

By signing below the patient and/or guarantor is confirming all of the information provided above is accurate, current and valid.
Al firmar a continuación el paciente y / o garante está confirmando que toda la información proporcionada anteriormente es exacta, actual y válida.

/ /_

Patient/Legal Guardian's Signature **Date**

FYZICAL®
Therapy & Balance Centers

Client Health Questionnaire

Patient Name: ______________________________________ Age: ___________ Date:_____/_____/______

Please describe your Current Complaint or Limitation: ______________________________________

Please describe how your problem began: ______________________________________

Please tell us how long ago your condition started:______________________________________

List tests or other interventions for this condition that you have had: ______________________________________

Please indicate the daily activities that you cannot perform: ______________________________________

Please indicate your level of functioning prior to the onset of this condition:______________________________________

Please inform us of any environmental or living conditions that may have difficulties with: ______________________________________

Did you have surgery? ☐ No ☐ Yes Date:_____/_____/______ Procedure: ______________________________________

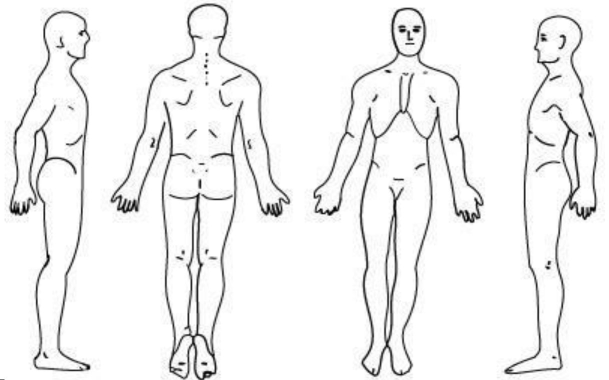
Please describe the nature of your symptoms (check **all** that apply):

☐ Vertigo
☐ Lightheadedness
☐ Imbalance
☐ Feeling "off"
☐ Ear Pressure/Pain
☐ Motion intolerant
☐ Migraine/Headaches
☐ Head Injury/Concussion
☐ Tinnitus (ear ringing)
☐ Sudden change in hearing

☐ Sharp Pain
☐ Dull (Pain) Ache
☐ Throbbing
☐ Numbness
☐ Shooting
☐ Burning
☐ Tingling

☐ Constant (76 – 100%)
☐ Frequent (51 – 75%)
☐ Occasional (26 – 50%)
☐ Intermittent (25% - or less)

Please Mark on the picture locations of pain



Level of symptoms at rest from 0 (No symptoms) to 10 (Unbearable symptoms) __________

Level of symptoms with activity from 0 (None) to 10 (Unbearable) __________

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Your symptoms are worse in: ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day

Activities or positions that increase symptoms: ______________________________________

Activities or positions that decrease symptoms: ______________________________________

Occupation:______________________________ Has your work status changed because of this condition ☐ Yes ☐ No

Pelvic Health Questionnaire ☐ **N/A**

Please describe your current compliant or limitation: ______________________________________

Please tell us how long ago your condition started: ______________________________________

List tests or other interventions for this condition that you have had: ______________________________________

Did you have surgery? ☐ Yes ☐ No Procedure: ______________________________________

# of Pregnancies:_______________ Vaginal Births:_______________ C-Sections: _______________

Date of last Pelvic Exam:_______________ Date of last Menstruation: _______________

Your symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increased During the Day

Activities or positions that increase symptoms: ______________________________________

Activities or positions that decrease symptoms: ______________________________________

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If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions, and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	CONDITION	
☐	☐	High Blood Pressure	
☐	☐	Angina	Present: Weight:___________Height:__________ft_________in.
☐	☐	Heart Attack	
☐	☐	Stroke	Have you fallen in the last year? ☐ No ☐ Yes-
☐	☐	Asthma	If yes, how many falls? _____________
☐	☐	HIV/AIDS	If you fell, did you have an injury? ☐ No ☐ Yes
☐	☐	Cancer: Location:_______Date:________	Type of Injury: ____________________
☐	☐	Tumor	Are you diabetic? ☐ No ☐ Yes
☐	☐	Systemic Lupus/	
☐	☐	Hepatitis	Do you use tobacco products? ☐ No ☐ Yes
☐	☐	Epilepsy	If yes, packs/day?_____/_____
☐	☐	Rheumatoid Arthritis	Pain 0 (no symptoms) to 10 (unbearable symptoms):
☐	☐	Arthritis	Current:_________ Best:_________Worst: _________
☐	☐	Pregnancy	
☐	☐	Drug or Alcohol Dependence	Hospitalization/Surgical Procedures
☐	☐	Hearing Loss	(list if not described elsewhere):____________________
☐	☐	Pace Maker	
☐	☐	Other ___________	____

Please fill in the following list of your medications (including supplements and over the counter medications)

Medication Name	Dosage	Frequency	Route

____ **Patient/Legal Guardian's Signature**

_____/_____/___________ **Date**

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