101 Tower Rd #210
Dakota Dunes, SD 57049
(605) 217-4330

FYZICAL Therapy & Balance Centers

12499 University Ave #250
Clive, IA 50325
(515) 985-7530

AUTHORIZATION FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AND ASSIGNMENT OF BENEFITIS

- Our office is happy to file your insurance claims for you. Please provide your insurance card and photo ID. You are required to pay your copay today upon checking out.
- If you do not have your insurance card, you will be required to prepay $200 and arrange payments for any remaining balance. Once you have supplied your insurance information, we will file your claim and refund you according to your benefits.
- If you do not have insurance coverage, you will be required to prepay $200 and must be prepared to make arrangement for any remaining balance with a post-dated check or visa/master card number upon checking out.
- My signature below gives Ear Nose and Throat Consultants/FYZICAL, and all providers within, my consent for treatment by means providers consider necessary and proper treatment of the identified patient. This treatment may require diagnostic procedures, audiology testing, laboratory testing and x-rays.
- My signature below authorizes ENT Consultants/FYZICAL to release or disclose information to the insurance companies and/or outpatient programs from my medical record pertaining to my treatment as needed to process claims.
- My signature below acknowledges that I am aware and financially responsible to ENT Consultants/FYZICAL for any and all charges not covered by this assignment.

Print Patient Name _____ **Date of Birth** _____/ _____ / _____

X_____ _____/ _____ / _____

Signature of patient / parent / or guardian **Today's Date**

HIPAA CONSENT FORM

I authorize Ear Nose and Throat Consultants and Hearing Services, PLC to release information that does contain private health information including but not limited to the following services: exams, lab and test results, prescription, purchased products, scheduling of appointments and scheduling surgery. You ***must*** check mark anyone who you want to be able to obtain information about you and your health. If you have been referred here by another physician, exam results will be sent to them automatically. I acknowledge I have been offered a copy of the Privacy Statement and I have no further questions.

Please circle: None Parents / Step Foster parents Spouse Cellular Home answering machine

Significant other (name)_____ Caregiver (name) _____

Interpreter (name) _____ Telephone number_____

In the event of an ***EMERGENCY,*** or if we are unable to reach you, please list someone ***outside of your household***

Name:_____ Telephone _____

☐By checking this box, I consent to have my FYZICAL medical records shared with my primary care provider.

X _____ _____/ _____ / _____

Signature of patient / parent/ or guardian **Today's Date**

***form valid for one year from today's date

101 Tower Rd #210
Dakota Dunes, SD 57049
(605) 217-4330

FYZICAL Therapy & Balance Centers

12499 University Ave #250
Clive, IA 50325
(515) 985-7530

Client Health Questionnaire

Name _____ Age _____ Date of Birth _____/_____/_____

Please describe your current complaint or limitation:_____

Please describe *how* and *when* your problem began:_____

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

Have you had other physical therapy or speech therapy this year? ☐NO ☐YES - If yes, how many sessions? _____

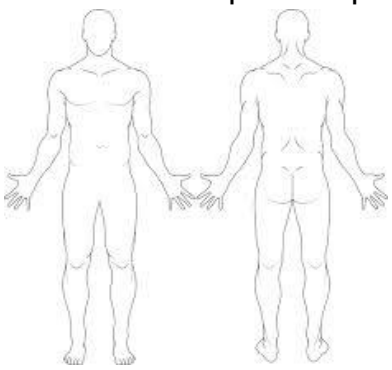
Please indicate the daily activities that you cannot perform: _____

Did you have surgery for this issue? ☐No ☐Yes Date ____/____/____ Procedure:_____

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

Dizziness/Imbalance:	**Pelvic Health:**	**Pain Description:**
☐ Spinning/vertigo	☐ Leaking urine	☐ Sharp Pain
☐ Lightheadedness	☐ Bladder urgency	☐ Dull (Pain) Ache
☐ Imbalance	☐ Leaking bowel	☐ Throbbing
☐ Feeling "off"	☐ Pain in pelvic region	☐ Numbness
☐ Motion intolerant		☐ Shooting
☐ Migraine/Headaches	**Symptom Frequency:**	☐ Burning
☐ Ear Pressure/Pain	☐ Constant (76 – 100%)	☐ Tingling
☐ Ringing in ears	☐ Frequent (51 – 75%)	
☐ Changes in hearing	☐ Occasional (26 – 50%)	
☐ Head Injury/Concussion	☐ Intermittent (25% - or less)	

Please mark locations of pain on the picture



Level of symptoms at ***worst*** from 0 (No symptoms) to 10 (Unbearable symptoms) _____
Level of symptoms at ***best*** from 0 (No symptoms) to 10 (Unbearable symptoms) _____
Activities or positions that increase symptoms: _____
Activities or positions that decrease symptoms: _____
Occupation _____

PAST PRESENT

- ☐ ☐ High Blood Pressure
- ☐ ☐ Angina
- ☐ ☐ Heart Attack
- ☐ ☐ Stroke
- ☐ ☐ Asthma
- ☐ ☐ HIV/AIDS
- ☐ ☐ Cancer – Location: Date:
- ☐ ☐ Tumor
- ☐ ☐ Systemic Lupus
- ☐ ☐ Hepatitis
- ☐ ☐ Epilepsy
- ☐ ☐ Diabetes
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Arthritis
- ☐ ☐ Pregnancy
- ☐ ☐ Incontinence
- ☐ ☐ Other_____
- ☐ ☐ Tobacco Use – packs/day:
- ☐ ☐ Drug or Alcohol Dependence

Present: Weight _____ Height _____ft _____in.
Have you fallen in the last year? ☐NO ☐YES - If yes, how many? _____

Medication: (Name/Dosage/Frequency/Route Administered)

_____

_____

_____

_____

****If you need additional room for medications please bring a separate document on your next visit**

Hospitalization/Surgical Procedures (list if not described elsewhere):

_____

_____

_____

Do you have a Pace Maker: ☐NO ☐YES

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

101 Tower Rd #210
Dakota Dunes, SD 57049
(605) 217-4330

FYZICAL Therapy & Balance Centers

12499 University Ave #250
Clive, IA 50325
(515) 985-7530

Account # _____ **Today's Date:** _____/_____/_____

PATIENT'S NAME: _____
(First) (M.I.) (Last)

PATIENT'S DATE OF BIRTH: _____ / _____ / _____ **PATIENT'S SSN**: _____ - _____ - _____

PATIENT'S ADDRESS: _____
(Street/PO Box) (City) (State) (ZIP)

PATIENT'S HOME PHONE: (_____)_____ **CELL PHONE:** (_____)_____

EMAIL ADDRESS: _____@_____

PATIENT'S EMPLOYER: _____ **PHONE:** (_____)_____

Preferred Contact Method: PHONE☐ EMAIL☐ TEXT ☐

Who is the insurance holder:_____ Relation to patient_____

Insured's: DOB _____/_____/_____ SSN:_____-_____-_____ Employer: _____

Referring Physician: _____ **Family Physician:**_____

Have you had any physical, occupational, or speech therapy this year? YES☐ NO☐

Do you wish to receive FYZICAL updates via email? YES☐ NO☐

Please Circle: Married Widowed Divorced Separated Single Common Law
Please Circle: Male Female
Please Circle: Black White Native American/Alaskan Native Hispanic/Latino Asian Other _____

Language Spoken:_____

How did you hear about us? Family Physician TV Website Billboard Social Media Internet Friend Other

If you are married, please complete the following information:
Spouse's Name: _____Date of Birth: _____/_____/_____Cell phone: (_____)_____

If patient is under 18, or under 26 on parent's insurance, complete the following information for *BOTH* parents:

Father's Name: _____
Address: _____
Phone: _____
Employer: _____
Work Phone: _____
SSN: _____ DOB: _____
Cell Phone: (_____)_____

Mother's Name: _____
Address: _____
Phone: _____
Employer: _____
Work Phone: _____
SSN: _____ DOB: _____
Cell Phone: (_____)_____