



Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Social Security # _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Emergency Contact: _____ Phone # _____ Relationship _____

Primary Care Physician / Family Doctor(s) _____

Are you currently under the care of a Home Health Agency? ___ No ___ Yes, name of Co. _____

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 Patient is a minor

Responsible party for bill if other than patient: _____ Relationship: _____

Responsible party's address (if other 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.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature: _____ Date: _____