FYZICAL
Therapy & Balance Centers

Crestview
728 N. Ferdon Blvd Ste. 3
Crestview, FL 32536
P: 850-682-7772
F: 888-308-1539
E: FrontDesk@FyzicalNWFL.Com

Niceville
4554 E Highway 20
Niceville, FL 32578
P: 850-897-7772
F: 888-308-1539
E: Niceville@FyzicalNWFL.Com

DeFuniak Springs
1030 US HWY 331 S Ste. C
DeFuniak Springs, FL 32433
P: 850-892-7772
F: 888-308-1539
E: DFS@FyzicalNWFL.Com

Patient Demographics

Patient Name: _____ DOB: _____ Gender: M / F Date: _____

If a minor, parent/guardian name(s): _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ SSN: _____-_____-_____

Email: _____ Marital Status: Single Married Widowed Divorced Separated

Emergency Contact: _____ Phone: _____ Relationship: _____

How would you like to receive appointment reminders? Y / N Preferred method: Text / Phone / Email/ None

Patient Information

- Have you had Physical, Occupational or Speech Therapy within the past 12 months? Y / N
- Have you received Home Health Care or Hospice Services within the past 12 months? Y / N
- Do you have an advanced directive? Y / N (If yes, please provide a copy for our office)
- Do you take any medications? Y / N (If yes, please list them on the sheet provided)

Referring Physician: _____ Primary Care Physician: _____

Please state your current problem(s): _____

Is this injury related to an auto accident? Y / N If yes, date of accident: _____State: _____

Is this a work-related injury? Y / N If yes, date of incident: _____ Employer: _____

Check if you currently have or have had any of the following:

__ Arthritis	__ Diabetes	__ Seizures
__ Asthma	__ Heart Problems	__ Stroke
__ Cancer	__ High Blood Pressure	__ Ulcers
__ Circulation Problems	__ Gout	__ Other

If Other, Please Specify:

_____

In general, how would you rate your overall health right now?
___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

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List Medications:

Name	Dosage	Frequency	Method	Condition

Allergies: _____

Major Surgeries: _____

Consent for Treatment

I/ we hereby authorize to receive care at FYZICAL Therapy and Balance Centers. I/ we understand that receiving physical therapy may involve engagement of musculoskeletal tissue that may cause soreness. Additional risks include, but are not limited to cardiovascular, muscle, ligament, joint or disc injury. Symptomatic aggravation of your current condition is possible. Furthermore, I/ we understand that the provider may need to perform mobilization technique, massage technique, manual traction, distraction, and other movement modalities and services that may produce brief soreness and discomfort. It is my/ our responsibility to communicate any difficulties that I/ we are having during treatment or any medical activity changes to my/ our provider. Please acknowledge consent with full knowledge of the nature and risks of evaluation and treatment program with your signature.

Print Name: _____

Signature: _____ **Date:** _____

PATIENT: _____

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Financial Policy and Benefit Assignment

I, the undersigned, hereby assign all medical benefits, IE: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to FYZICAL Therapy and Balance Centers. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize FYZICAL Therapy and Balance Centers to release all medical information and records necessary to secure payment for services rendered.

Primary Insurance

Carrier: _____ Policy No. _____ Group: _____ In Network: Y / N

Subscriber Name: _____ Subscriber DOB: _____ Referral Required: Y / N

Auth Required: Y / N Auth No. _____ Auth Eff: _____ Auth Exp: _____ No. Visits: _____

Deductible Amount: _____ Deductible Remaining: _____ Copay: _____ Co-Insurance: _____

Max Coverage: $_____ Limitations: _____Visits/ _____ Medicare PT Cap Remaining: $_____

Secondary Insurance

Carrier: _____ Policy No. _____ Group: _____ In Network: Y / N

Subscriber Name: _____ Subscriber DOB: _____

This coverage determination does **NOT** guarantee payment by insurance. We encourage you to call Customer Service to verify your eligibility and coverage as described above. It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full.

All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by FYZICAL Therapy and Balance Centers, you must promptly remit such payment directly to FYZICAL Therapy and Balance Centers.
If you are a Worker's Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is successfully controverted.
If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees, and/or a reasonable attorney fee.

Please give the office 24 business hours to cancel or reschedule your appointment, otherwise you may be subject to a $40.00 administrative fee.

I have read the above information, and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Print Name: _____ **Signature:** _____ **Date:** _____

PATIENT: _____

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Privacy Policy

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within the clinic for the purpose of providing you with quality care.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the clinic receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.
- Your confidential health information may not be released via text message. You are advised to call your healthcare professional should you have any questions or concerns.
- Your confidential healthcare information may be released to other healthcare providers in the event you need continued care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential health information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by the clinic by phone, text or email to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. You may notify the clinic in writing if you do not wish to receive these contacts.
- You have the right to restrict the use of your confidential healthcare information. However, the clinic may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The clinic is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- The clinic will abide by the terms of this notice. The clinic reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- All complaints will be investigated. No personal issue will be raised for filing a complaint with the clinic.
- You have the right to complain to the clinic if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the clinic:
- For further information about this Privacy Notice, please contact: Tiffany Jones at (850) 682-7772.
- **This notice is effective as of 1/28/14. This date must not be earlier than the date on which the notice is printed or published.**

Print Name: _____

Signature: _____ **Date:** _____

Is there anyone you would like to grant access to your medical records? If so, please list them here:

1.) _____
2.) _____
3.) _____

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Client Needs Screen (CNS)

	Yes	No
1.) Have you had a fall in the past year?		
2.) Do you have a fear of falling?		
3.) Would you like your balance to be assessed?		
4.) Do you experience dizziness or imbalance?		
5.) Do you lose your balance when stepping up/down stairs or steps?		
6.) Do you have a difficult time walking in the dark?		
7.) Do you have difficulty hearing?		
8.) Do you have osteoporosis, osteoarthritis or joint pain?		
9.) Do you take bone and/or joint supplements?		
10.) Do you experience muscle aches, pains and/or muscle cramping?		
11.) Do you use cold, heat or compression therapy at home?		
12.) Are you interested in learning how compression clothing with ice could help your condition?		
13.) Are you interested in learning how home heat and/or cold therapy could help your condition		
14.) Do you have foot and/or ankle pain/discomfort?		
15.) Do you currently wear shoe inserts?		
16.) Are you interested in learning about how a shoe insert could help your condition?		
17.) Do you have pain and/or physical challenges other than what you are being seen for today?		
18.) Would you like to get more information about your whole body health?		
19.) Are you interest in learning how a medically based fitness program could safely optimize your physical condition?		

PATIENT: _____

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Consent for Treatment of a Minor

I give permission for my child to be medically evaluated and treated at FYZICAL Therapy and Balance Centers. I understand that it may be necessary to perform diagnostic test during treatment. I also understand that patients ages 12 or older may be treated within the facility without a chaperone. I reserve the right to notify FYZICAL Therapy and Balance Centers in writing if a personally designated chaperone will be required at any point in my child's treatment. Furthermore, if my child requires a personally designated chaperone, I retain the responsibility of coordinating appointments to meet the needs of the patient's customized physical therapy action plan.

1. Complete Physical Therapy Evaluation
2. .Physical Therapy Treatments (Including Manual Stretching, Soft Tissue Mobilization, Myofascial Release, Joint Mobilization, Ultrasound, and Electrical Stimulation
3. First Aid and Emergency Care

I DO NOT give permission for the following services to be performed without my presence in the office at the time said services are performed:

_____

_____

My child may be accompanied by the following person(s):

□ Unaccompanied

□ Caregiver (name): _____

□ Other (Name & Relationship): _____

I give permission for the provider treating my child to share any relevant health information with the person accompanying my child.

_____ _____
Child's Name Date

_____ _____
Parent/Guardian Name Parent/Guardian Signature

PATIENT: _____