FYZICAL Therapy & Balance Centers

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

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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? _____

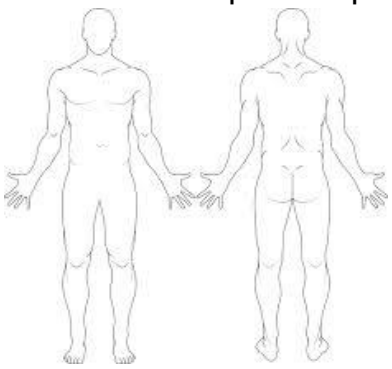
Please indicate the daily activities that you cannot perform: _____

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

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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: (_____)_____

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INFORMED CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred to a pelvic health therapist for an evaluation and treatment of pelvic floor dysfunction and related impairments of the pelvic girdle. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist(s) or their trained assistant(s) to perform an internal pelvic floor muscle and pelvic girdle examination. This examination will include, but is not limited to assessment of skin condition, reflexes, muscle tone, length, strength, and endurance, scar mobility, and function of the pelvic floor region. It may be necessary to perform an internal pelvic floor evaluation by inserting a gloved finger(s) into the perineal region including the vagina and/or rectum.

Treatment of the pelvic floor region and/or pelvic girdle may include, but is not limited to the following: observation, palpation, use of vaginal weights and other tools, vaginal and/or rectal sensors for biofeedback and/or electrical stimulation, heat, ice/cryotherapy, stretching and strengthening exercises, soft tissue and/or joint mobilization and education instruction.

I understand that I will have the opportunity to give/revoke my consent at each treatment session. Verbal consent will continuously be obtained throughout each session and I am always in control of my own body and what is performed during sessions at physical therapy. I understand that I may request further patient education at any time during my therapy plan of care.

I understand that I have the option to have a second person in the room for the pelvic floor evaluation and treatment (as described above). The second person present, besides myself and the treating/evaluating therapist, can be a friend, family member, or clinic staff member. Please indicate your preference with your initial below:

___ YES I want a second person present during the pelvic floor evaluation and treatment.
___ NO I do not want a second person present during the pelvic floor evaluation and treatment.
___ I would like to discuss my options with my treating therapist prior to consenting.

Potential Risks: I acknowledge that a full pelvic floor evaluation and/or pelvic floor treatment may increase my current level of pain or discomfort, or an aggravation of my existing injury/symptoms. This discomfort is usually temporary. If it does not subside in 1-3 days, I agree to contact my therapist and/or physician.

Potential Benefits: A full pelvic floor evaluation and/or pelvic floor treatment may improve my symptoms and increase my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance of my pelvic girdle muscles. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition/impairments and will be more aware of the resources available to me.

No Warranty: I understand that the therapist(s) cannot make any promises or guarantees regarding a cure for improvement of my condition. I understand that my therapist(s) will share their opinion with me regarding potential results of physical therapy and will discuss all treatment options before I consent to treatment based on subjective and objective examination findings.

I have informed my therapist(s) of any condition** that would limit my ability to have an evaluation or treatment performed to the perineal/pelvic region including internal palpation of the vagina and/or rectum. I hereby request and consent to the evaluation and treatment to be provided.

By signing below, I agree that I have read and understand the INFORMED CONSENT FOR PELVIC FLOOR EVALUATION AND TREATMENT, and that I consent to the evaluation and treatment of my pelvic floor/pelvic girdle. Below I will list any concerns, requests, or stipulations necessary to proceed with evaluation and/or treatment that I have consented to:

Patient Signature _____ Date _____

If you are or may be pregnant, have an infection within or near the pelvic region, have an IUD or other implants, have a sexually communicable disease, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity or allergies to lubricant, vaginal creams or latex, please inform the therapist(s) prior to the pelvic floor evaluation and treatment session.

FYZICAL Therapy & Balance Centers

Cancellation and No Show Policy

Dear Patient:

We strive to meet and exceed expectations of all our patients and we are dedicated to rendering excellent physical therapy care to you and the rest of our patients. In order to meet the needs of all of our patients, we are implementing a cancellation and no-show policy. This policy enables us to better utilize available appointments for our patients.

Physical therapy does not function the same as a primary care office. We only provide one on one care and only schedule a maximum of twelve patients per therapist per day to give you the best quality individualized care. If you are not here, we are unable to see another patient.

We understand situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide at a minimum 24 hours' notice. When sufficient notice is not given to reschedule your appointment, it does not give enough time to contact another patient who could come to the clinic during your assigned time. This results in patients not getting the care they need, when they need it.

We remind you of your appointment two business days prior to your appointment via phone reminder and via email (when email is provided).

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered a **NO SHOW**. Patients will be subject to a **$20.00** fee for not showing to an appointment. Patients who no-show two (2) or more times in a 12 month period, may not be recalled.

An office appointment is defined as a cancellation with less than 24 hours notification. A cancellation reason is determined by the office. Cancellation accruals of three (3) appointments will result in a **$20.00** fee.

NOTE: THESE FEES ARE NOT COVERED BY YOUR INSURNACE COMPANY AND ARE THE SOLE RESPONSIBILITY OF THE PATIENT AND MUST BE PAID IN FULL BEFORE NEXT APPOINTMENT.

We want the best for our patients and believe a good provider/patient relationship is based on communication.

Please sign that you have read and understand this No Show and Cancellation policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date Signed

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NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, initiate payment, or conduct health care operations for other purposes permitted or required by law. The medical practice reserves the right to make changes in the Notice of Privacy Practices. The Notice describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health condition and related health care services.

For a more complete and detailed version of this privacy practice notice, make your request known at the front desk.

We understand that medical information about you and your health is personal, and we are committed to protecting it. A record of the care and services you receive at this practice is created and maintained at this location.

We are require by law to:

- Make sure that medical information that identifies you is kept private
- Provide you this notice of our legal duties and privacy regarding your medical information
- Follow the term of the notice that is currently in effect

The following categories describe ways that we use and disclose medical information about you:

- Treatment
- Payment
- Healthcare operations
- Third party business associates such as billing or transportation

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternative or other health-related benefits and services that may be of interest to you. Your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our privacy officer to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclose of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your healthcare will be disclosed.

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly related to that person's involvement in your healthcare. We may use or disclose your protected health information in an emergency treatment situation.

We may use or disclose your protected health information in the following situations without your consent or authorization:

- Required by law
- Public health
- Communication diseases
- Health oversight
- Abuse or neglect
- Food and Drug Administration
- Legal proceeding
- Law enforcement
- Coroners, funeral directors, and organ donation
- Worker's compensation
- Inmates
- Sale of closure of the practice

Your rights:

- Inspect and copy your protected health information
- Request a restriction of your protected health information
- Request to receive confidential communications from us by alternative means or location
- Have your physician amend your protected health information
- Receive an accounting of certain disclosures we have made, if any
- Receive a paper copy of this notice from us
- File a complaint

You may file a complaint to our office or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. You will not be penalized or retaliated against for filing a complaint.