



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

- 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



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? _____

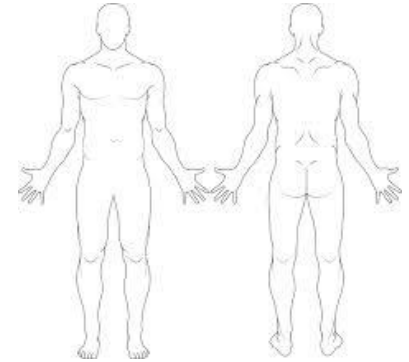
Please indicate the daily activities that you cannot perform: _____

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

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

Please mark locations of pain on the picture

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

- | | | | |
|--------------------------|--------------------------|----------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer – Location: | Date: |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor | |
| <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy | |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinence | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use – packs/day: | |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence | |

Present: Weight _____ Height _____ ft _____ in. Have you fallen in the last year? <input type="checkbox"/> NO <input type="checkbox"/> 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: <input type="checkbox"/> NO <input type="checkbox"/> 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



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: _____

Mother's Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Employer: _____

Employer: _____

Work Phone: _____

Work Phone: _____

SSN: _____ DOB: _____

SSN: _____ DOB: _____

Cell Phone: (____)____

Cell Phone: (____)____



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 INSURANCE 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



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 required 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 disclosure 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.