FYZICAL™
Therapy & Balance Centers

17817 Davenport Road, Ste. 230
Dallas, TX 75252
(P) 972-732-7797 (F) 972-732-7794

Patient Information

Last Name: _____First Name: _____Middle Initial _____

Address _____

City _____State: _____ Zip _____

Date of Birth _____Sex _____Social Security #_____ Marital Status _____

Home Phone #:_____Work Phone #:_____Cell #:_____

Emergency Contact: _____Phone #_____Relationship_____

Primary Care Physician _____Referring Physician_____

Are you currently under the care of a Home Health Agency? ____No ____Yes, name of Co._____

How did you hear about Fyzical™? _____

Insurance Information

Insurance Policy #_____Group # _____

Policyholder's Name _____Relation to Patient _____DOB _____

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 am responsible for a $25 fee for any cancellations or no show that are not done prior to 24 hours of appointment.**

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

Patient/Responsible Party Signature_____Date:_____

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MEDICAL HISTORY

Do you have, or have you had, any of the following?

☐ Anemia	☐ Heart Attack	☐ Neck Stiffness
☐ Allergies	☐ Heart Disease	☐ Pacemaker / Defibrillator
☐ Asthma	☐ High Blood Pressure	☐ Perforated Ear Drums
☐ Balance Disorders	☐ Hypoglycemia	☐ Radiation Treatment within 3 months
☐ Bowel/Bladder Incontinence	☐ Infectious Disease	☐ Ringing In Ears
☐ Cancer	☐ Kidney Problems	☐ Seizures
☐ Chest Pain	☐ Liver / Gallbladder Problems	☐ Shortness Of Breath
☐ Depression	☐ Metal Implants	☐ Skin Rashes
☐ Diabetes	☐ Nausea/Vomiting	☐ Stroke
☐ Dizziness/Fainting	☐ Open Wound	☐ Thyroid Problems
☐ Epilepsy	☐ Osteoarthritis	☐ Tingling in Arms/Hands
☐ Excessive Fatigue	☐ Osteoporosis	☐ Typhoid/cholera/Dysentery
☐ Headaches	☐ Neck Pain	
OTHER-		

Encounter Pain performing the following:

Bending	○N/A	○ Mild	○Severe	○Unable	**Self-care bathing**	○N/A	○ Mild	○Severe	○Unable
Carrying groceries	○N/A	○ Mild	○Severe	○Unable	**Self-care shaving**	○N/A	○ Mild	○Severe	○Unable
Climbing stairs	○N/A	○ Mild	○Severe	○Unable	**Sleep**	○N/A	○ Mild	○Severe	○Unable
Computer Use	○N/A	○ Mild	○Severe	○Unable	**Static sitting**	○N/A	○ Mild	○Severe	○Unable
Driving	○N/A	○ Mild	○Severe	○Unable	**Static standing**	○N/A	○ Mild	○Severe	○Unable
House chores	○N/A	○ Mild	○Severe	○Unable	**Self-care dressing**	○N/A	○ Mild	○Severe	○Unable
Kneeling	○N/A	○ Mild	○Severe	○Unable	**Sexual activities**	○N/A	○ Mild	○Severe	○Unable
Lifting ^ 10lbs	○N/A	○ Mild	○Severe	○Unable	**Sports**	○N/A	○ Mild	○Severe	○Unable
Lifting ^ 35lbs	○N/A	○ Mild	○Severe	○Unable	**Walking**	○N/A	○ Mild	○Severe	○Unable
Reading	○N/A	○ Mild	○Severe	○Unable	**Yard work**	○N/A	○ Mild	○Severe	○Unable

BALANCE

Have you fallen 2x or more with the last 12 months?	○YES	○NO	How many times? _____
Have you Fallen 1x or more with an injury?	○YES	○NO	

PLEASE INCLUDE MEDICAL PRESCRIPTIONS; OVER THE COUNTER; AND SUPPLEMENTS

Medications Name	Dose	How often taken	Reason	Oral/Injection/Topical

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American Specialty Health (ASH)
P. O. Box 509077, San Diego, CA 92150-9077

INITIAL HEALTH STATUS

PTOTST - FAX 877-248-2746

Patient Name _____ **Subscriber ID** _____ **Primary Language** _____

Describe your current problem and how it began_____

_____

_____

Onset date/surgery date __/_____/_____

Is This? ☐ Work related ☐ auto related ☐ N/A

How often do you experience your symptoms?

☐ Constantly (76%-100%) ☐ Frequently (51%-76%)
☐ Occasionally (26%-50%) ☐ Intermediately 0%-25%

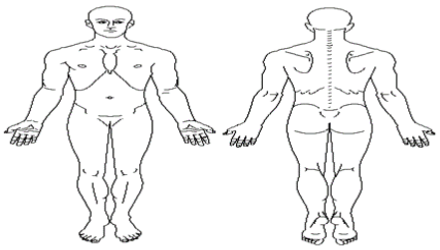
Describe the nature of your pain:

☐Sharp ☐Dull Ache ☐Numb ☐Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐Getting Better ☐Not Changing ☐Getting Worse

PAIN DRAWING



Current complaint (how do you feel today)

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Check if you have difficulty: ☐Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

What is your most effective learning method: ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

In general how is your overall health at this time? ☐ Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Have you had x-rays, MRI, and CT scan for your area(s) of complaint ☐ yes ☐ no

If yes Date(s) - _____ what were taken_____

Check all the following that apply to you:

☐ Alcohol/drug dependency
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (date) _____
☐ Dizziness/ fainting
☐Cancer/tumor (explain) _____
_____
☐ Osteoporosis
☐Other health problems (explain) _____
_____

☐ Numbness (location) _____
☐ Urinary Problems
☐ Currently pregnant, # weeks_____
☐ Abnormal Weight ☐ gain ☐ loss
☐ Pain Unrelieved by position or rest
☐ Pain at night
☐ Surgeries _____
_____
☐ Tobacco use – type _____
frequency _____/day
☐ Current medications _____
_____

Who have you seen for your condition before today?

☐No one ☐Medical Doctor ☐Massage Therapist ☐Other _____
☐Chiropractor ☐Physical Therapist ☐Acupuncturist ☐Occupational Therapist ☐speech Therapist

What treatment did you receive and when? _____

What is your Occupation? _____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature_____ **Date**_____

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PATIENT RIGHTS DISCLOSURE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION COULD BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO YOUR INFORMATION AND THE OPERATION OF THE PRACTICE. PLEASE REVIEW IT CAREFULLY AND SIGNED THE BOTTOM.

At Summit Physical Therapy, PA /DBA Fyzical Therapy & Balance Center (Fyzical) our mission is giving someone back his or her lifestyle through the work of Physical Therapy. We work diligently on helping to relieve pain and strengthen our patients so they can return to their regular activates. The clinical staff consist of Teena Petree, PT and Benjamin Selbo PT, DPT whom are board certified and licensed physical therapist; Lisa Mendiola, PTA and Ciarra Moran, PTA are board certified Physical Therapist Assistants. They are all regulated by the state of Texas Physical Therapy Association and able to treat all patients that are referred to physical therapy by their physicians with prescription.

Your medical records will be kept confidential in our office at all times. They are kept in cloud based software with no access to them except for our staff. We will not disclose any information in your records to anyone without your written consent and this will include any family member. We call to remind you of your appointments on the number you left on file and we will leave a message on your voice mail or with anyone that picks up the phone. There are limited times we will disclose your records for billing purposes or to your referring physician on continuation of treatment. If you are using insurance we send your records in the following order:

- We use Hands on Technology for the software and Zirmed for the clearinghouse to send your billing electronically.
- Your insurance company receives all your information, but should they request additional information to review and process your claims we will send it to them by mail, fax or e-mail.

Any other uses and disclosure must be made by you (the Patient) and with a written authorization that we will keep in your file. You have the right to revoke this written authorization at any time as long as we get written notification.

Patient Rights

- You can request restriction on certain uses and disclosures of your records.
- You can request access to copies of and amendments to your records, however there is a fee of $25 for records.
- You can request confidential communications.
- You can obtain an accounting disclosure that would have required an authorization.
- You can complain about privacy practices to us and HHS.
- If the privacy officer denies a request you have the right to appeal to the reviewing officer.

Privacy Officer is:

Dolores Lolo-Englert – Office Manager

972-732-7797 Hours Mon – Friday 11am to 4pm

Reviewing Officer

Teena Petree, PT / Owner

972-732-7797 Hours Mon-Friday 11am-3pm

Patient Signature _____ Date _____

YOUR SIGNATURE CONFIRMS YOU HAVE READ AND ARE AWARE OF THE ABOVE NOTIFICATION ON YOUR FIRST VISIT WITH FYZICAL.

We have the HIPAA Notice available please let the front desk know and they will provide you a copy.