



Informed Consent Form

In order to initiate services, we need your signature on this authorization form.

Patient's Name: _____ Date of Birth: _____

AUTHORIZATION FOR EVALUATION &/OR TREATMENT, AND RELEASE OF INFORMATION

(Initial on the line indicates consent, N/A if not applicable).

_____ I consent for this provider to render the evaluation and treatment set forth above as ordered by my physician.

_____ **I am a self-referral** and I consent for this provider to render physical therapy evaluation and treatment for my problem: _____

_____ I authorize the release of my healthcare information necessary for treatment and/or to process claims for services rendered by this provider.

_____ I consent for this provider to render physical therapy evaluation and treatment **via telephone (e-visits) or the internet (hereinafter referred to as Telehealth)**

REIMBURSEMENT COVERAGE:

_____ I request and authorize the patient's insurance coverage to make payments of authorized benefits on the patient's behalf to this provider.

_____ I understand that I am responsible for paying any deductible, co-insurance, co-pay and for any non-insured services authorized above.

_____ COLLECTION OF DELINQUENT ACCOUNTS SHALL BE SUBJECT TO SERVICE CHARGES PER MONTH PLUS ATTORNEY'S FEES, COURT COST AND ALSO COLLECTION FEES.

Signature of Patient or Patient Representative **Date**

If someone has signed, print name and relationship to patient:

Name _____ Relationship to Patient _____



NOTICE OF PRIVACY PRACTICES Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of EG Rehab Solutions, LLC (d.b.a FYZICAL Therapy & Balance Centers).

Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

Our *Notice of Privacy Practices* is subject to change. If we change our *Notice*, you may obtain a copy of the revised *Notice* by visiting our website at <https://www.fyzical.com/fort-ben-in/For-Patients> or on request from your health care team.

I acknowledge receipt of the *Notice of Privacy Practices* of FYZICAL Therapy & Balance Centers.

Signature: _____ Date: _____

Circle One: (Patient / Parent / Conservator / Guardian)

My initial below acknowledges:

_____ EG Rehab Solutions, LLC d.b.a FYZICAL Therapy & Balance Centers can leave a confidential message and/or appointment reminder (circle if applies to only one)

Cell phone: _____

Home phone: _____

Email: _____

_____ EG Rehab Solutions, LLC d.b.a FYZICAL Therapy & Balance Centers may send promotional, event information, and/or health and wellness tips

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good fair efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgment was not obtained:

Signature of provider representative: _____ Date: _____

Reasons why the acknowledgment was not obtained:

_____ Patient refused to sign

_____ Other or Comments: _____

PAST MEDICAL HISTORY

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

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Balance |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Bowel / Bladder Issues (Incontinence) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Fever, Higher than 100 Degrees F |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Liver / Gallbladder Problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Low Exercise Level |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Open Wounds | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker or Defibrillator |
| <input type="checkbox"/> Perforated Ear Drums | <input type="checkbox"/> Radiation Treatment within the last 3 months |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ringing In Ears |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness Of Breath/Difficulty Breathing |
| <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Stomach or Intestinal Issues |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tingling In Arms / Hands | <input type="checkbox"/> Tingling In Legs / Feet |
| <input type="checkbox"/> Typhoid/cholera/dysentery | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Other Health Issues (please explain) | |

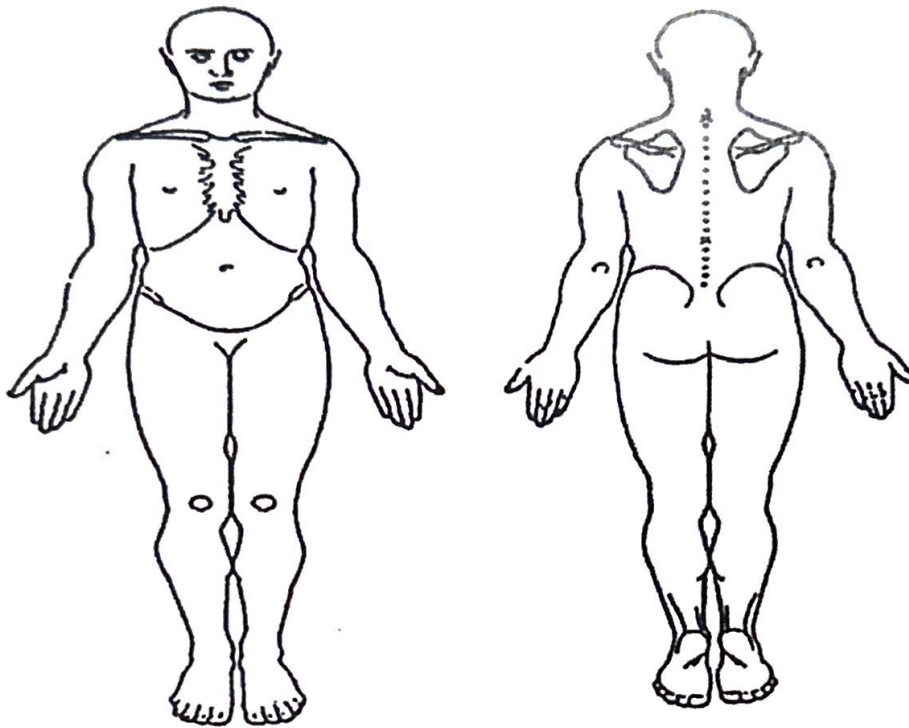
Are you taking any medication? Yes _____ No _____

If yes, please list
medications _____

NAME _____ DATE _____

PRESENT CONDITION: PAIN / TENSION

Please place an "X" in the area or areas where you are experiencing pain/symptoms.



Please circle the words that best describe your pain.

- | | | | |
|---------|---------------------|-----------|----------|
| SEVERE | DULL | STABBING | MODERATE |
| BURNING | NUMBNESS / TINGLING | THROBBING | WEAKNESS |
| SHARP | RADIATING | | |

Please rate your pain from 0 (no pain) to 10 (worst imaginable pain) at

Worst	0 1 2 3 4 5 6 7 8 9 10
Now	0 1 2 3 4 5 6 7 8 9 10
Best	0 1 2 3 4 5 6 7 8 9 10



Appointment Attendance, Cancellation, and No-Show Policy

Research shows that patients who attend all scheduled therapy sessions are **93% more likely to achieve a full recovery**. **Missing even one appointment** can significantly impact your progress.

To ensure every patient has the opportunity to receive the care they need, please review and acknowledge the following policies:

- We will work with you to schedule all recommended appointments following your evaluation and will send text and email reminders for appointments
- To maximize your treatment time, please arrive at least 5 minutes before your scheduled appointment, dressed appropriately and ready to begin
- If you are late, we cannot guarantee that your full treatment session can be completed. If you are more than 15 minutes late, your session may be rescheduled, and a missed visit fee may apply
- Chronic tardiness may require a change in your appointment schedule
- If you are running late, please call us immediately so we can inform your therapist and adjust as needed
- A session shortened due to a late arrival will still be considered a completed appointment
- A minimum of 24 hours notice is required for all cancellations or appointment changes during business hours
- Late cancellations and no-shows prevent us from offering care to other patients in need
- **A \$25 missed visit fee will be charged for appointments cancelled without 24 hours notice, in compliance with payer policies**
 - After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. FYZICAL will assist you to reschedule this appointment if needed.
 - If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a \$25.00 no show fee.
 - If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second \$25 no show fee assessment.
 - Multiple same-day cancellations or no-shows may result in removal from the active schedule and placement on a day-to-day availability list. Your referring physician will also be notified.
 - For Worker's Compensation patients, we are required to notify your claims adjuster of any missed appointments
- Your credit card on file will be charged the No-Show/Missed visit fees when assessed and/or we may not choose to offer service until your balance is paid

We are committed to working with you to achieve the best possible outcomes. Thank you for your understanding and cooperation in helping us provide the highest quality of care.

Patient Name

Date of Birth

Date

Patient Signature or Parent/Guardian if minor

Relationship to Patient