FYZICAL®
Therapy & Balance Centers

Welcome to FYZICAL Therapy & Balance Centers!

Please spend a few moments completing the attached forms. This will allow our front desk staff to set up your chart with the required information.

It will also allow your therapist to understand your current situation, and to assist in goal setting necessary for your personalized treatment plan.

If you have any questions, please feel free to ask the receptionist at our front desk.

Thank you,

The Team at FYZICAL Gainesville

Patient Acknowledgement Form

Please Read and Initial:

_____ I consent to **evaluation and treatment** by FYZICAL Therapy and Balance Centers and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ The filling of insurance claims is a courtesy that we extend to our patients. **You will be responsible for any charges not reimbursed or contractually adjusted by your insurance company.** Should your claims not process as you expected or should you have any questions regarding your insurance plan benefits, Please contact your insurance company directly.

_____ I authorize the **release of information** acquired in the course of my treatment including by not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, other third party payers and/or the following (i.e spouse, family member, friend: _____)

_____ I authorize **phone, e-mail, and/or text messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ I have received and/or been offered a copy of this facility's **Notice of information/ Privacy Practices** has been provided to me.

_____ Medicare beneficiaries have an annual cap for combine therapy services including Physical, Occupational, and Speech Therapies.

_____ A $35.00 charge will be charged for any returned checks.

_____ Should a patient account become 60 days past due the account will be placed with a collection agency and a $35.00 collection fee will be charged.

_____ I hereby **assign** to FYZICAL Therapy and Balance Centers all payment for medical services rendered to myself or my dependants. **I understand I am responsible for any amount not covered by my insurance.**

_____ **I understand I will be charged a fee of $5.00 to 25.00 for cancelled or missed appointments without 24 hour notice. Payment must be rendered prior to next scheduled visit.**

_____ _____

Patient Signature Today's Date

_____ _____

Patient Legal Representative Today's Date

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Client Health Questionnaire

Name _____ Age _____ Date _____/_____/_____

Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

Please tell us how long ago your condition started: _____

List tests or other interventions for this condition that you have had: _____

Please indicate the daily activities that you cannot perform: _____

Please indicate your level of functioning prior to the onset of this condition: _____

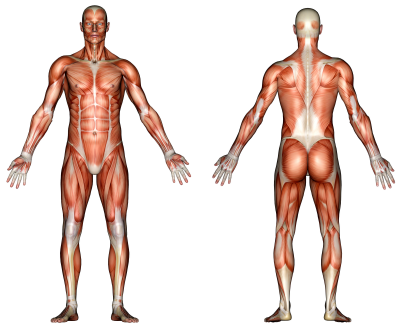
Please inform us of any environmental or living conditions that may have difficulties with: _____

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

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

☐ Vertigo	☐ Sharp Pain	☐ Constant (76 – 100%)
☐ Lightheadedness	☐ Dull (Pain) Ache	☐ Frequent (51 – 75%)
☐ Imbalance	☐ Throbbing	☐ Occasional (26 – 50%)
☐ Feeling "off"	☐ Numbness	☐ Intermittent (25% - or less)
☐ Ear Pressure/Pain	☐ Shooting	
☐ Motion intolerant	☐ Burning	
☐ Migraine/Headaches	☐ Tingling	
☐ Head Injury/Concussion		

Please Mark on the picture locations of pain



Level of symptoms at rest from 0 (No symptoms) to 10 (Unbearable symptoms) _____
Level of symptoms with activity from 0 (No symptoms) to 10 (Unbearable symptoms) _____
Since this condition began your symptoms have:☐decreased ☐not changed ☐increased
Your symptoms are worse in:☐morning ☐afternoon ☐night ☐increased during the day ☐same all day
Activities or positions that increase symptoms: _____
Activities or positions that decrease symptoms: _____
Occupation _____ Has your work status changed because of this condition ☐YES ☐NO If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assist your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure Angina
☐	☐	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

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Patient Information

Last Name: _____First Name: _____Middle Initial:_____

Email: _____Address:_____

City:_____State: _____ Zip:_____

Date of Birth:_____Sex:_____Social Security #_____

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

Marital Status: Single_____Married_____Divorced_____Widowed_____

Emergency Contact: _____Phone #_____Relationship_____

Primary Care Physician / Family Doctor(s)_____

Are you currently under the care of a Home Health Agency?____No____Yes, name ofCo._____

How did you hear about FYZICAL ?_____

Insurance Information

Medicare #_____ Part B effective date_____

Insurance Policy #_____Group #:_____

Policyholder's Name: _____Relation to Patient:_____DOB:_____

Insurance Address (if other than above):_____

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

Patient/Responsible Party Signature:_____Date:_____