CLEAR

FYZICAL®
Therapy & Balance Centers

Name: Last First Initial Birthdate (--/--/---)

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____ Gender:
Home Mobile Work

Email: _____ Preferred Appointment Reminder: ◯ Text ◯ Email ◯ Call

Did this condition result in surgery? No◯ Yes◯ If Yes, date of surgery: _____

Is this condition due to a work Injury? No◯ Yes◯ If Yes, date of accident: _____

Are you currently receiving Home Health? No◯ Yes◯ If Yes, from whom? _____
(i.e. any healthcare worker, aide assisting or doing something to or for you?)

Do you live in a nursing home? No◯ Yes◯ If Yes, what is its name? _____

Office Phone: (____) _____-_____

Dr.'s Name: Last First Initial MD, DO, DDS, Other

Address: Street City State Zip Code

If you do not have a referring doctor, please indicate "Direct Access": _____

(5) Payer Information Primary:

Insurance Plan: **I am aware of my Physical Therapy Benefits: Yes☐ No☐**

Primary Insurance: _____ **ID #** _____ **Group #** _____

Secondary Insurance: _____ **ID #** _____ **Group #** _____

Medication/Drug or Supplement Name	Dosage	Medication/Drug or Supplement Name	Dosage

Cancellation Policy

FYZICAL Therapy & Balance Centers' cancellation policy requires a notification of 24 hours in advance to avoid any fees applied to your account. A $75 fee is applied when 24-hour notice is not provided. This policy is to ensure we can provide essential services to all patients. FYZICAL accepts cancellations over the phone, by email, through FYZICAL's texting software Klara, and in-person.

Assignment of Insurance Benefits

I authorize that the payment of my insurance benefits be made directly to FYZICAL for any services that are reimbursable by Medicare or any other insurance company.

Guarantee of Payment

I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date. Outstanding balances may be subject to late fee.

Certification of Information

I certify that the information I have provided FYZICAL for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

_____ _____

Patient or Legal Representative's Signature **Today's Date**

FYZICAL®

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: _____

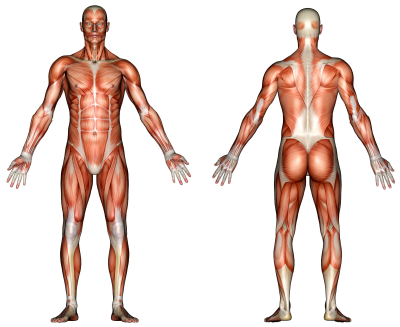
Please describe the nature of your symptoms (check **all** that apply):

☐ Vertigo
☐ Lightheadedness
☐ Imbalance
☐ Feeling "off"
☐ Ear Pressure/Pain
☐ Motion intolerant
☐ Migraine/Headaches
☐ Head Injury/Concussion

☐ Sharp Pain
☐ Dull (Pain) Ache
☐ Throbbing
☐ Numbness
☐ Shooting
☐ Burning
☐ Tingling

☐ Constant (76 – 100%)
☐ Frequent (51 – 75%)
☐ Occasional (26 – 50%)
☐ Intermittent (25% - or less)

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

CONSENT TO NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.
For judicial & administrative proceedings according to specific requirements.
I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that the Notice of Privacy Practices covers all service areas of Physical Therapy & Balance Centers. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. If I wish to review the document, I will make a request in writing.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Unless you object, we will call, text or email to confirm an appointment and/or leave a message, call, text, or email you regarding your account (at the phone number or email provided by you), call, text, or email and/or leave a message regarding treatment and or test results.

Patient Name - Printed

Patient Signature

Date