FYZICAL®

Patient Information

Last Name: First Name: Middle Initial:

Address:

City: State: Zip:

Date of Birth: Sex: Email Address:

Home Phone #: Work Phone #: Cell #:

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact: Phone#: Relationship:

Referring Physician: Phone #:

Primary Care Physician / Family Doctor(s) Phone #:

Are you currently under the care of a Home Health Agency? ☐ No ☐ Yes, name of Co.

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:

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. I understand that I have the right to refuse any physical therapy service(s) offered if I so choose. I understand that physical therapy may involve some risk and I hereby release FYZICAL from liability now and in the future.

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 appropriate third parties.

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 but not limited to 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 uncovered 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 understand and agree to the terms above.

Patient/Responsible Party Signature Date: