FYZICAL

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Email: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: _____ SSN: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Primary Care Physician/ Family Doctor (s): _____

Are you currently receiving Physical Therapy services? _____No _____Yes, name of company _____

How did you hear about Fyzical? : _____

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 physical 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.

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:** _____

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Personal Information:

Height ___ ft ___ in Weight _____

Marital Status: ◻ single ◻ married ◻ divorced

Employment Status: ◻ Employed Full-time ◻ Employed Part- time ◻ Unemployed ◻ Student ◻ Disabled

◻ Not working because of illness

If you are currently employed, what best describes your job: ◻ Desk work ◻ Manual Labor

Living Situation: ◻ Live alone ◻ Live with spouse/family ◻ Assisted- living facility

About Your Current Complaint:

Is this complaint auto related? Yes ◻ No ◻

Have you had or are you currently seeing another physical therapist for something else? Yes ◻ No ◻

Have you fallen in the last 12 months? ◻ Yes ◻ No

Are you currently receiving home health or other therapy services? ◻ Yes ◻ No ___

What is the complaint that brought you here? _____ _____

When did this problem begin, or recently become worse? _____ ___

What caused this problem? _____ _____

Does this problem affect your activity choice, tolerance, efficiency or effectiveness? Yes ◻ No ◻

If "Yes", what activities? _____ _____ _____ _____
What makes your problem better? _____
Worse?_____

Does this complaint affect your comfort, mood, or ability to sleep? Yes ◻ No ◻

What symptoms are you experiencing with this complaint:
Swelling ___Loss of motion ___weakness___loss of balance or coordination ___numbness___tingling
___Other_____

How frequent are the symptoms experienced? ◻ Constant ◻ Intermittent

How much pain are you experiencing? ◻ None ◻ Very Mild ◻ Mild ◻ Moderate ◻ Severe ◻ Very Severe

What tests have you had for this complaint? ◻ X-Ray ◻ CAT Scan ◻ MRI ◻ Myelogram ◻ Bone Scan

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Medical History:

Please check all medical conditions you have, or have had:

□ High blood pressure □ Diabetes □Pacemaker □ Stroke/TIA □ Vertigo □ Asthma □ HIV/AIDS □ Cancer

□ Tumor □ Concussion □ Heart Attack □ Neuropathy □ Epilepsy/Seizures □ Arthritis □ Hearing Loss

□ Pregnancy □ Bowel/ Bladder Problems □ Tobacco use □ Drug or alcohol use

□ Other: _____

Please list surgeries:

_____

_____

_____

_____

Please list all medications you are currently taking:

_____

_____

_____

_____

Please list all allergies:

_____

_____

_____

FYZICAL THERAPY ATTENDANCE POLICY

FYZICAL Dizziness and Wellness Center strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellation, especially at the last minute, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

If you are more than 20 minutes late for your appointment and failed to notify us, treatment may be cancelled and a fee assessed for that appointment.

A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE to avoid being charged a $50.00 missed appointment fee.

Failure to show up for an appointment without notifying us will result in a fee being charged for that appointment. Furthermore, 3 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.

At week's end, ALL PATIENTS, regardless of insurance/third party payor will be charged $50.00 CANCELLATION FEE for each late, late-cancelled and no-show appointment. The PATIENT is responsible for the fee, not the insurance.

No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.

All cancellations and no shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor

Repeated failure to comply with this attendance policy will result in your name being placed on a "schedule based on availability" List. This will require you to call for an open appt. on each day that you would like to receive therapy. We will do everything possible to accommodate you, as space permits.

We believe that this policy is necessary for the benefit of all our patients so that we may continue to provide high quality treatment and service to everyone. All of the staff at FYZICAL Dizziness and Wellness Center appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

_____ ___/___/___

Signature Date