FYZICAL THERAPY & BALANCE CENTERS

Name:_____ Date:_____

Address:_____ Home Phone:_____

City:_____ Cell Phone:_____

State:_____ Zip:_____ Work Phone:_____

Emergency Contact:_____ Emergency Phone Number:_____

Referring Physician:_____ GP, if not referring MD:_____

Date of Birth:_____ Sex: M / F Marital Status:_____

Social Security #: _____-_____-_____ Email Address:_____

Occupation: Employed Unemployed Retired Student

If employed, type of employment:_____

How did you hear about Fyzical Therapy & Balance Centers? (Circle) Doctor Friend/Family (Who?:_____)
Other: _____

Consent to Treatment:
I am entering a Physical Therapist/Patient Relationship today and am consenting to allowing the physical therapist to obtain information throughout questioning, the laying of hands-on by way of physical exam, and performing special tests, to arrive at a plan of care to treat the problem I am seeking medical attention for today. I understand that as a competent adult I do not have to accept anything that my physical therapist instructs me on even if there may be grave bodily injury to myself if I should forego his/her recommendations. I also understand that if I refuse treatment or am consistently non-compliant with his/her recommendations, that the physical therapist, who must try, under ethical terms, to provide beneficence and non-malfeasance to his/her patients may elect to end the Physical Therapist/Patient Relationship that has been established. The physical therapist will provide me with a list of alternative physical therapists that can provide my continued care. I also understand that I may at any time end this relationship with my physical therapist.

_____**INITIALS**

Allowance of Third Party Insurers to Pay Providers Directly
By initialing below, I agree that all payments regarding the delivery of services by a Fyzical Therapy & Balance Centers Physical Therapy employee, be paid directly to Fyzical Therapy at its business address. This will remain in effect until revoked by me (patient) in writing. I understand that I am responsible for all charges whether or not paid by said insurance. I further understand and agree that if Fyzical Therapy must take action to collect any outstanding balance on my account, I will be responsible for payment of and will reimburse Fyzical Therapy for all costs such as collection efforts, including but not limited to all court costs and attorney fees. All unpaid account balances will be considered delinquent sixty (60) days from the date of the charge. At the time of the visit, the appropriate insurance co-payment is due in full, if applicable. Interest may be assessed on all delinquent accounts at a monthly rate of 1.5%.

_____**INITIALS**

Cancellation Policy
In order for you to get the most out of your physical therapy, please honor that a twenty-four hour notice must be given prior to a cancellation of an appointment. If you fail to give proper notice there will be a late cancellation fee of $50.00. This also applies to patients who fail to show up for a scheduled appointment.

_____**INITIALS**

Blue Cross Blue Shield Patients Only
Occasionally BCBS will send payment and explanation of benefits directly to the patient. As your provider of services, it is vital that we receive this information so we can make the proper adjustments to your account. Therefore, it is your responsibility to bring or mail all checks and correspondence you receive from BCBS to Fyzical Therapy. If you do not, you will receive a bill for the full, unadjusted amount.

_____**INITIALS**

Fyzical Therapy & Balance Centers
Lakewood Ranch

5860 Ranch Lake Blvd, Suite A
Bradenton, Florida 34202

Phone: 941-417-8300
Fax: 941-417-8301

Patient Medical History

Your medical history is very important information for us to ensure your safety during your rehabilitation process. Please be as complete and honest as possible with your answers, and feel free to discuss your history with your therapists.

Please inform us if you have had a history of the following (check all that apply):

□ Allergies
□ High Blood Pressure
□ Asthma
□ Kidney Disease
□ Broken Bones
□ Liver Disease
□ Cancer
□ Neurological Condition
□ Chest Pain
□ Osteoarthritis
□ Chronic Bronchitis
□ Osteoporosis/Osteopenia
□ Depression
□ Dizziness
□ Pace Maker
□ Shortness of Breath
□ Polio
□ Diabetes
□ Pneumonia
□ Stomach Ulcers
□ Emphysema/COPD
□ Rheumatic/Scarlet Fever
□ Heart Disease
□ Ringing in Ears
□ Headaches
□ Bowel/Bladder Dysfunction
□ Hepatitis/ Jaundice
□ Stroke
□ Low Blood Sugar
□ Urinary Tract Infection
□ Seizures
□ Hard of hearing
□ Vision problems
□ Other _____

Have you recently experienced any of the following? PLEASE CIRCLE

□ Persistent pain at night
□ Fever or Night Sweats
□ Pregnancy
□ Shortness of Breath
□ Frequent Nausea or Vomiting
□ Recent Weight Loss/Gain
□ Frequent or Severe Abdominal Pain
□ Significant change or loss of control of bowel/bladder

Please list *and* give dates of any significant surgeries you have had in the past 5 years:

_____

_____

Medications (please list all information for each, if you do not know please bring information next visit)**:**

Name	Dosage	Frequency	Route of Adminsitration
			ORAL OTHER:
			ORAL OTHER:
			ORAL OTHER:
			ORAL OTHER:
			ORAL OTHER:
			ORAL OTHER:

Body Mass Index:

Height: _____ Weight:_____

Falls:

Have you fallen in the past 12 months? YES NO

Number of Falls: _____

If you answered YES to the above question, did you sustain an injury from your fall?

Please explain: _____

1. Are you (*circle one*): **Right-handed Left-handed**
2. Are you currently receiving any Home Health Services, or have you recently received Home Health Services for any condition? (i.e. Home Health Aide/Nurse/Therapy)? YES/ NO
3. Have you had any form of therapy this year, for ANY condition? YES/ NO If yes, when? _____
4. If your injury is the result of an Automobile accident or a Worker's Compensation claim please complete the following**: Date of Accident/Injury _____ State _____ Claim # _____**

*****Current Health Status (please circle yes or no):**

5. Do you smoke? **YES/NO**
6. Do you drink more than one alcoholic beverage per day? **YES/ NO**
7. Do you exercise regularly**? YES/ NO**
8. On average, how many days per week do you exercise?_____For how long? ____ Type of exercise?_____
9. Leisure Activities/Hobbies_____
10. Are you pregnant? **YES/NO**
11. During the past month have you been feeling down, depressed or hopeless? **YES/NO**
12. Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES/NO**

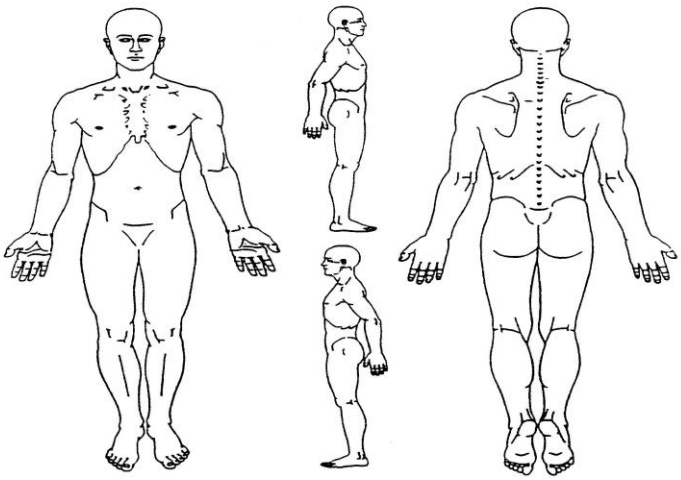
Current Condition

Describe the main problem for which you seek physical therapy services?

_____

When did the problem begin? (Approximate date): _____

Please Mark Appropriately:
X (Pain) ///-Stabbing
O (Numbness/Tingling) □-Throbbing



Pain Level:
Please circle your pain level from 0-10 (0 indicates NO pain, while 10 indicates the need for a visit to the emergency room), indicate one number for pain at its worst and best:

0 1 2 3 4 5 6 7 8 9 10

Please check any of the following tests you have had for this problem:

□ X-rays	□ Blood Tests	□ GI Tract Testing
□ CT scan	□ EMG	□ EKG
□ MRI	□ Urine Culture	□ Other:_____
□ Bone Scan	□ Urodynamic Testing	□ Other:_____
□ Dexa Scan	□ Laparoscope	□ Other:_____

_____ _____

Patient Signature Date

I certify the above information is true to the best of my knowledge; I will notify you immediately of any changes to my status or information listed above.

Patient-Specific Functional Scale

Instructions:

Please list 3 activities that you are UNABLE to do or have moderate to extreme difficulty doing as a result of your injury or pain level. For each of the activities that you list, RATE the level of difficulty you have performing each activity using 0-10 scale listed below. On the 0-10 scale, the HIGHER the number, the EASIER you can perform the activity. The LOWER the number, the more DIFFICULTY you have.

(Example: Dressing, sleeping, work duties, climbing stairs, etc.)

Patient-specific activity scoring scheme (Pick one number):

O = Unable to perform activity

10 = Able to perform activity at same level as before injury or problem

Activity	0	1	2	3	4	5	6	7	8	9	10
1.											
2.											
3.											

(Therapist will score)

Total score = sum of the activity scores/number of activities Minimum detectable change (90% CI) for average score = 2 points Minimum detectable change (90% Cf) for single activity score <<3 points

PSFS developed by: Stratford, P., Gill, C, Westaway, M., & Binkley, J. (1995). Assessing disability and change on the individual patients: a report of a patient specific measure. Physiotherapy Canada, 47,258-263.

Patient Name_____ Date_____

Client Name: _____

Date: _____

Case #: _____

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Therapy & Balance Centers

Client Needs Screen (CNS)

1. Have you had a fall in the past year?	❑ Yes	❑ No
2. Do you have a fear of falling?	❑ Yes	❑ No
3. Would you like your balance to be assessed?	❑ Yes	❑ No
4. Do you experience dizziness or imbalance?	❑ Yes	❑ No
5. Do you lose your balance when stepping up/down curbs or stairs/steps?	❑ Yes	❑ No
6. Do you have a difficult time walking in the dark?	❑ Yes	❑ No
7. Do you have difficulty hearing?	❑ Yes	❑ No

8. Do you have osteoporosis, osteoarthritis and/or joint pain?	❑ Yes	❑ No
9. Do you take bone and/or joint supplements?	❑ Yes	❑ No
10. Do you experience muscle aches, pains and/or muscle cramping?	❑ Yes	❑ No
11. Do you use cold, heat or compression therapy at home?	❑ Yes	❑ No
12. Are you interested in learning how compression clothing with ice could help your condition?	❑ Yes	❑ No
13. Are you interested in learning how home heat and/or cold therapy could help your condition?	❑ Yes	❑ No

14. Do you have foot and/or ankle pain/discomfort?	❑ Yes	❑ No
15. Do you currently wear show inserts?	❑ Yes	❑ No
16. Are you interested in learning about how a shoe insert could help your condition?	❑ Yes	❑ No
17. Do you have pain and/or physical challenges other than what you are being seen for today?	❑ Yes	❑ No
18. Would you like to get more information about your whole body health?	❑ Yes	❑ No
19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	❑ Yes	❑ No

Summary of Notice of HIPAA Privacy Practices

This summary notice of privacy practices serves to inform you how Fyzical Therapy & Balance Centers may use and disclose your protected health information (PHI). Fyzical Therapy creates and maintains a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to protect the health information that identifies you and to inform you of our legal duties and privacy practices.

Uses and Disclosures of Protected Health Information (PHI) by Patient Consent

- **Treatment**: We may use PHI to provide you with health care treatment or services. This includes but is not limited to discussions with referring physicians to plan care and treatment.
- **Payment**: We may use and disclose PHI to third party or insurance company to obtain benefit information and prior approval for treatment or to justify medical care.
- **Health Care Operations**: We may use and disclose PHI to ensure that you are receiving the highest quality of care possible.

Uses and Disclosures of Protected Health Information (PHI) as required by Law

We will disclose PHI about you when required to do so by federal, state, or local law. Such examples are:

- To avert a serious threat to health or safety
- For military personnel or veterans to Dept. of Veterans Affairs
- Supply information regarding Worker's Compensation claims to insurance companies, case managers, or employers
- Public health risks
- In response to a subpoena, court order, or other lawful request
- Health Oversight Agency for activities authorized by law (audits, investigations, etc)
- Law Enforcement requests
- Coroners or Health Examiners
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Your Rights as a Patient to your Protected Health Information (PHI)

You have the following rights:

- To inspect and copy your medical records
- To request an amendment to your medical records although Fyzical Therapy & Balance Centers are not required by law to change your records
- To request an accounting of the disclosures that Fyzical Therapy & Balance Centers have made
- To request restrictions or limitations on your PHI
- To request confidential communications
- To obtain a copy of this notice at any time

*For all requests, please note that Fyzical Therapy & Balance Centers has 30 days to respond to your request and have the right to charge you copying fees.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary or the Department of Health and Human Services. To file a complaint with us, please contact the Privacy Officer at 941-417-8300. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Changes to this Notice

Fyzical Therapy & Balance Centers has the right to change this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as information we receive in the future.

Consent to Use and Disclose Protected Health Information (PHI)

By signing this document, I agree to truthfully, completely, and correctly provide all requested information to Fyzical Therapy & Balance Centers. Additionally, I am giving consent to Fyzical Therapy & Balance Centers to use and disclose my protected health information for treatment, payment and health care operations.

Patient Name (PRINTED):_____

Signature of Patient, Guardian, or POA:_____ Date:_____

FYZICAL®
Therapy & Balance Centers

We promise to give you:

- **One on one** care from the Therapist
- To be treated as an **individual**, not a condition
- Value and respect your **time**
- Decisions are made **with you**, not for you
- **Comprehensive** treatment plan based on your personal goals
- **Personalized** care

For us to fulfill our promise, we need the following from you:

- Please be **on time**, your time is very valuable, if you are late, unfortunately we will need to shorten your treatment time
- You follow the **Plan of care**
- You follow our **home instructions**
- You follow our **customized Home Exercise Program**
- You **communicate** with us regarding any changes or challenges to meeting your goals
- Call **24 hrs** ahead of time to cancel or reschedule
- Cancellation fee of **$50**. If you fail to give a minimum of 24 hours notice. It not only takes away from your goals, it also takes away from the therapist and other patients that could have benefited from using your time slot.

Patient Signature:_____ Date:_____

Fyzical Therapy & Balance Centers

Acknowledgement of Receipt of Patient's Right to Report Complaints, Abuse

Pursuant to Florida Regulation 408.810(5), patients must be in informed of their right to report complaints or abuse to the Agency for Healthcare Administration via a statewide, toll-free number.

Complaints: To report a complaint regarding the services you receive, please call toll free: **888-419-3456**.

Abuse: To report abuse, neglect or exploitation, please call toll free: **800-96-ABUSE.**

By signing below, I acknowledge that I have received information regarding the Patient's Right to Report Complaints and Abuse.

_____ Date:_____