FYZICAL®
Therapy & Balance Centers

Welcome to our office

We look forward to providing you with world class service. At FYZICAL we strive to provide comprehensive care of the whole person and total body wellbeing . Our highly trained staff will work on your behalf to elevate your current health status and help you LOVE YOUR LIFE!

Authorization for Treatment

Physical therapy services offered at FYZICAL includes, but not limited to: evaluation techniques, soft tissue techniques, manual therapy techniques, heat, cold, electrical stimulation, electrical modalities, paraffin, stretching activities, strengthening exercises, cervical/lumbar traction, and the use of gym and/or Pilates equipment.

I have been informed that if any soft tissue technique, particularly Graston technique / active release / cross-fiber friction mobilization, are used, it may cause bruising and tenderness in the region that is/was treated. If the technique is too uncomfortable I will bring it to the attention of my physical therapist so that the procedure can be modified or ceased.

I consent to the rendering of physical therapy care by FYZICAL I also 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 Vegas from liability now or in the future.

Assignment of Insurance Benefits and Release of Information

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits, insurance payments be made to FYZICAL and its affiliates . I authorize payment of medical benefits to FYZICAL Vegas and its affiliates.

Personal Valuables/Dependents/Visitors

It is understood and agreed that FYZICAL is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, if children are present, please keep them off the exercise equipment in order to prevent injuries. There may be exceptions, please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of small children.

Financial Agreement

I, the undersigned agree, to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that FYZICAL and its affiliates bill participating insurance companies as a courtesy. I understand that all co-payments, coinsurance, deductibles are due at the time of service. I understand that benefits quoted to me are only an estimate. I understand that it is my full responsibility to know and understand my health plan. I understand that FYZICAL Vegas is not responsible for any inaccurate information they receive from my insurance co. I understand that it is my responsibility to obtain necessary referrals from my doctor prior to coming to FYZICAL, if required by my insurance. Should the account be referred to an agency or attorney for collections, I agree to pay attorney's fees and collection expense. I also agree to pay $25 for any returned checks.

Credit Card/Debit Card Payments By signing this form you authorize FYZICAL and its affiliates to keep your credit card on file for future payments. You have the option to decline this convenience and physically produce your card on any visit. If you decline this option please initial here _____.

Cancellation / No-Show Policy

Missed appointments represent a cost to FYZICAL, to you, and to other patients who could have been seen in the time slot set aside for you. Cancellations are requested 24 hours prior to the appointment time. We reserve the right to charge for missed or late-canceled appointments. Excessive cancellation/no-show of appointments may result in discharge from the practice. If you need to cancel or reschedule an appointment, please feel free to call us during our business hours. 702-818-5000 . You may even text us at 702-FYZICAL . By signing below you agree to pay $40 for all physical therapy appointments that are not canceled 24 hours prior to your scheduled treatment session.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As indicated in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you are stating that you have reviewed the Notice of Privacy Practices. You may request a written copy of the Notice at any time. You may also ask any questions about the Notice at any time.

I HAVE FULLY READ AND UNDERTSAND ALL THE ABOVE CONTENTS AND AGREE TO ACCEPT ITS TERMS

Signature of Patient or Responsible Party	Print Name	Date

FYZICAL®
Therapy & Balance Centers

Date: _____/_____/_____

Name: _____
(LAST) (FIRST) (MIDDLE)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____- _____ Cell: ( ) _____-_____

SSN : _____ -_____-_____ Date of Birth: _____/_____/_____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Employer: _____ Occupation: _____

Employer's Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By : _____ Area of Injury : _____

Type of Injury : ☐ Work Related ☐ Sports Injury ☐ Auto Accident ☐ Other: _____

Your e mail address: _____

SPOUSE AND/OR GUARDIAN INFORMATION

Name: _____ D.O.B._____/_____/_____ SSN: _____-_____-_____

Relationship: _____ Employer: _____ Occupation:_____

Emergency Contact: _____ Relationship: _____ Phone # : _____

INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance Name: _____

Address: _____Phone#: _____

Name of Insured: _____ ID# _____ Group# _____

SECONDARY INSURANCE
Insurance Name: _____

Address: _____Phone#: _____

Name of Insured: _____ ID# _____ Group# _____

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits, insurance payments be made to FYZICAL Vegas. I authorize payment of medical benefits to FYZICAL Vegas.

Patient Signature: _____ Date: _____