Patient Registration Form (Formulario de registro de pacientes)

By accurately filling out this form in its entirety and with legible handwriting we will have better success in billing a clean claim to your insurance company. (Al rellenar con precisión este formulario en su totalidad y con la escritura legible, tendremos mejor éxito en la facturación de una reclamación limpia a su compañía de seguros.)

Patient Information Información del paciente

Last Name (Apellido)	**First Name** (Nombre)	**Middle** (Segundo)
Mailing Address (Dirección)		**Apt/Condo#** (Apartamento#)
City (Ciudad)	**State** (Estado)	**Zip** (Código postal)
Home Phone (Telefono)	**Cell Phone** (Telefono Cellular)	**Email** (Correo Electronico)

Approved method of contact for appointment reminders and other electronically generated messages. Circle all that apply
Método de contacto aprobado para recordatorios de citas y otros mensajes generados electrónicamente. Círculo de todos los que se aplican

Text (Texto) Voice (Voce) Email (Correo Electronico)

Date of Birth (Fecha de Nacimiento) M D Y	**Gender** (Género) Female (Mujer) Male (Hombre)	**Social Security Number** (Número de Seguro Social)
Marital Status (Estado civil) Single Married Widowed Other	**Employer's Name** (Empleador)	**Occupation** (Ocupacion)
Emergency Contact Person (Nombre de Contacto de emergencia)	**Emergency Contact Phone#** (Telefono de emergencia)	**Relationship to Patient:** (Relacion con el paciente)
Related cause to why you are being seen in our office (Causa relacionada por la que lo están viendo en nuestra oficina) Work Injury Auto Accident Surgery Other		**Injury Date or Surgery Date:** (Fecha de lesion o cirugia) / /
Referring Physician or Name of Primary Care Physician	**Name of Practice Group**	**Date of Last Visit with Physician** / /
Insurance Name #1	**Policy/ID Number**	**Group Number**
Insurance Name #2	**Policy/ID Number**	**Group Number**

Spouse and or Guardian Information Información del cónyuge or tutor

Last Name (Apellido)	**First Name** (Nombre)	**Date of Birth** (Fecha de Nacimiento) M D Y
Social Security Number (Número de Seguro Social)	**Relationship to Patient:** (Relacion con el paciente)	**Employer's Name** (Empleador)

Is the patient is receiving home health services currently? YES NO
(¿El paciente recibe actualmente servicios de salud en el hogar?)

Has the patient received home health services in the past 30 days? YES NO
¿Ha recibido el paciente servicios de salud en el hogar en los últimos 30 días?

Are you receiving physical therapy services elsewhere? (Even for a non-related diagnosis). YES NO
¿Recibe servicios de fisioterapia en otro lugar?

By signing below the patient and/or guarantor is confirming all of the information provided above is accurate, current and valid.
Al firmar a continuación el paciente y / o garante está confirmando que toda la información proporcionada anteriormente es exacta, actual y válida.

Patient/Legal Guardian's Signature **Date** / /

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Consent to Treatment

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.

2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that treatments offered at Fyzical may involve some risk and I hereby release Fyzical from liability now and in the future. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.

3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.

4. worker's Compensation - I hereby authorize Fyzical receive my records related to my work injury.

Photo/Video Authorization

I grant to Fyzical and its affiliated entities, and its representatives (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager.

Notice of Privacy Practices

By signing this form, I acknowledge that Fyzical has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations, I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Fyzical representatives.

PT Benefits Provided by Your Insurance Company

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Fyzical if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment. I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that I have the right and responsibility to follow-up with my insurance for specific questions regarding my individual policy.

Communication: I consent to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information including via phone, text, and email.

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name:	Relationship:

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information:

Patient Name (please print):

_____

Patient or Guardian Signature:

_____

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Client Health Questionnaire

Patient 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: _____

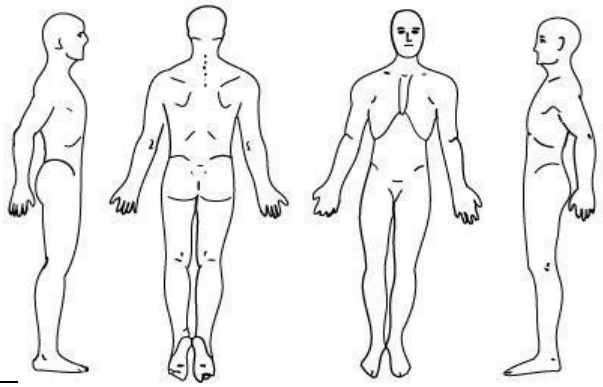
Please inform us of any environmental or living conditions that may have difficulties with: _____

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
- ☐ Tinnitus (ear ringing)
- ☐ Sudden change in hearing
- ☐ 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 (None) to 10 (Unbearable) _____

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

Pelvic Health Questionnaire ☐ **N/A**

Please describe your current compliant or limitation: _____

Please tell us how long ago your condition started: _____

List tests or other interventions for this condition that you have had: _____

Did you have surgery? ☐ Yes ☐ No Procedure: _____

# of Pregnancies: _____ Vaginal Births: _____ C-Sections: _____

Date of last Pelvic Exam: _____ Date of last Menstruation: _____

Your symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ Increased During the Day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

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 assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	CONDITION
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Cancer: Location:_____Date:_____
☐	☐	Tumor
☐	☐	Systemic Lupus/
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Drug or Alcohol Dependence
☐	☐	Hearing Loss
☐	☐	Pace Maker
		Other _____

Present: Weight:_____Height:_____ft_____in.

Have you fallen in the last year? ☐ No ☐ Yes-
If yes, how many falls? _____
If you fell, did you have an injury? ☐ No ☐ Yes
Type of Injury: _____

Are you diabetic? ☐ No ☐ Yes

Do you use tobacco products? ☐ No ☐ Yes
If yes, packs/day?_____/_____

Pain 0 (no symptoms) to 10 (unbearable symptoms):
Current:_____ Best:_____Worst: _____

Hospitalization/Surgical Procedures
(list if not described elsewhere):_____

Please fill in the following list of your medications (including supplements and over the counter medications)

Medication Name	Dosage	Frequency	Route

_____ _____/_____/_____

Patient/Legal Guardian's Signature **Date**

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Medicare Questionaire

Medicare beneficiaries over age 65

1. Are you currently working full or part time? Yes / No
2. Are you married? Yes / No
   a. If so , does your spouse work full or part time? Yes / No
   b. If yes, how many employees does your spouse's employer have? _____
3. Are you covered under an employer group health plan on your current employment , or current employment of a spouse? Yes / No
4. Are you entitled to Black Lung Medical Benefits Yes / No
5. Was this service for the treatment of a work-related injury? Yes / No
6. Was this service for the treatment of illness or injury which resulted from auto/other accident? Yes / No
7. Are the service to be paid by a government program such as a research grant? Yes / No
8. Has the department of veterans Affairs(DVA) authorized and agreed to pay for care at this facility ? Yes / No

Screening for Future Fall Risk

Medicare defines a fall as a sudden, unintentional change in position causing you to land at a lower level, on an object, the floor or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure or overwhelming external force.

1. Have you had two or more falls in the past year? Yes / No
2. Have you had any fall resulting in injury in the past year? Yes / No

Home Health / Skilled nursing facility

1.Have you received ANY home health care in the last 60 days? Yes / No

2.Were you admitted to a skilled nursing facility in the last 60 days? Yes / No

If Yes, provide the last date of service: _____

Name of Agency : _____

Patient signature :_____

For office use only

Called agency to confirm the Discharge date : Fyzical Staff signature: _____

Spoke to _____ at _____/___/___ , patient discharged on _____/___/____