FYZICAL Therapy & Balance Centers

PATIENT INFORMATION

Patient Name: (Last, First, Middle) _____

DOB: _____ *Sex*: ___Female ___Male

Address: _____ *City/State/Zip Code*: _____

Email: _____ *Home*: _____ *Cell*: _____

***Emergency Contact*:**

Name: _____ *Relationship*: _____ *Phone#*: _____

Do we have permission to discuss your medical conditions with another person? Yes / No

Name: _____ *Relationship*: _____ *Phone#*: _____

How did you here about us? _____

Primary Care Physician:_____ *Next MD Appt* _____

Party Responsible for Payment of Medical Services: _____

Are you receiving any Home Healthcare Services? Yes / No

If you are on Medicare and receiving home health, you must be discharged from home health services. If you have not been discharged please note you will be responsible for the cost of services.

_____ _____

Patient/Guardian Signature **Date**

FYZICAL Therapy & Balance Centers

INSURANCE INFORMATION

Please have your insurance card available for us to make a copy.

Primary Insurance Name: _____ Subscriber DOB: _____

Subscriber Name: _____ Relationship to Patient: ___Self ____Parent ___Other

Member ID/Policy#: _____ Group #: _____

Secondary Insurance Name: _____ Subscriber DOB: _____

Subscriber Name: _____ Relationship to Patient: ___Self ____Parent ___Other

Member ID/Policy#: _____ Group #: _____

AUTOMATIC BILL PAY AGREEMENT

We now **require** an HSA, credit or debit card to be on file with our office for the outstanding balance due to co-payments, deductibles, and non-covered services. We will charge these cards for all patient responsibility amounts on or around the 15th and/or 30th of each month. If you do not want to provide a credit card on file, you will be responsible for paying any balance due at the time of service IN FULL prior to scheduling any future appointments.

Please specify below your preference on how you would like for us to process your automatic payment.

Every visit ☐ **15th and/or 30th** ☐

Credit Card Information

Card holder's Name: _____
Type: Visa Master Card Discover American Express
Card Number: _____
Expiration Date: _____ CVC# _____ Billing Zip code: _____

Cardholder's Signature: _____ **Date:** _____

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AUTHORIZATION FORM

- I hereby give consent to the providers at FYZICAL Therapy and Balance Centers for treatment.
- I authorize FYZICAL Therapy and Balance Centers to bill my insurance company for my physical therapy evaluation and treatments.
- I authorize FYZICAL Therapy and Balance Centers to release to my insurance company, third party insurance, or their medical review companies, all medical information necessary to secure payment for my physical therapy services.
- I authorize all payment for services to be made directly to FYZICAL Therapy and Balance Centers.
- I authorize FYZICAL Therapy and Balance Centers to communicate with me via e-mail, protected health information such as billing statements and therapy reports. I understand that FYZICAL Therapy and Balance Centers server is not encrypted.
- I acknowledge that I am wholly responsible for full payment to FYZICAL Therapy and Balance Centers for all physical therapy services rendered, including all applicable co-payments and any amounts not paid by insurance. In the event that FYZICAL Therapy and Balance Centers has entered into an agreement with my insurance company to reduce their rates, FYZICAL Therapy and Balance Centers will not bill me any PPO agreed upon reductions. In the event of default, any legal and collection fees necessary in collecting my account will be my responsibility.
- I authorize my physician to release to FYZICAL Therapy and Balance Centers any medical or other information necessary for my Physical Therapist to fully understand my condition and plan an appropriate treatment plan. I also authorize FYZICAL Therapy and Balance Centers to release information to my physician regarding my treatment plan and progress during physical therapy.
- I acknowledge FYZICAL Therapy and Balance Centers' cancellation and payment policies. I understand there is a $40 "No-Show" and/or "Late Cancellation" fee if I do not give 24-hour notice of my intent not to attend a scheduled appointment. If you reschedule the cancelled appointment within the next 7 days, we will waive the $40 fee.

Your signature below indicates your consent and agreement to the above statement terms as shown on this page.

Patient/Guardian Signature _____ **Date** _____

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Client Needs Survey

Balance:

- Do you experience dizziness or imbalance? **Y / N**
- Do you have a fear of falling? **Y / N**
- Have you had a fall in the past year? **Y / N**
- Would you like your balance to be assessed? **Y / N**

Headaches:

- Do you experience headaches? **Y / N**
- In the past 30 days, how often have you had a headache?
  1-5 days ____ 6-10 days ____ 11-15 days ____ 16+ days____
- Do you experience any of the following with your headaches?
  (Check all that apply)

  Sensitivity to light, noise and smells____ Nausea and vomiting___
  Upset stomach & belly pain___ Loss of appetite___ Fatigue___
  Feeling very warm or cold___ Pale skin___ Dizziness___
  Blurred vision___ Diarrhea___
- Would you like a referral to a physician who specializes in managing headaches? **Y / N**

Incontinence:

- Do you have to rush to the bathroom? **Y / N**
- Do you go to the bathroom "just in case"? **Y / N**
- Do you go to the bathroom more than 8 times per day? **Y / N**
- Would you like to speak with a therapist who specializes in this? **Y / N**