FYZICAL
Therapy & Balance Centers

PATIENT INFORMATION

Patient Name: (Last, First, Middle) _____

DOB: _____ *Sex*: ___Female ___Male

Parent/Guardian #1:

Name: _____ *DOB*: _____

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

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

Parent/Guardian #2:

___ Same Address

Name: _____ *DOB*: _____

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

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

How did you hear about us? _____

Primary Care Physician:_____ *Next MD Appt* _____

Party Responsible for Payment of Medical Services: _____

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

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

_____ _____

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.

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:** _____

FYZICAL Therapy & Balance Centers

AUTHORIZATION FORM

- I hereby give consent to the providers at FYZICAL Therapy and Balance Centers for treatment for my child.

- I authorize FYZICAL Therapy and Balance Centers to bill my insurance company for my child's physical/occupational 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 child's physical/occupational 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/occupational 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 child's physician to release to FYZICAL Therapy and Balance Centers any medical or other information necessary for my child's Physical/Occupational Therapist to fully understand my child's condition and plan an appropriate treatment plan. I also authorize FYZICAL Therapy and Balance Centers to release information to my child's physician regarding their treatment plan and progress during physical/occupational 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** _____