FYZICAL®
Therapy & Balance Centers

Patient Information

Last Name: _____First Name: _____Middle Initial:_____
Address:_____

City:_____ State: _____ Zip:_____ Date of Birth:_____ Sex:_____ Social Security #:_____
Home Phone #:_____Work Phone #:_____Cell #:_____

Email Address: _____

Marital Status:
Single_____Married_____Divorced_____Widowed_____ Emergency Contact: _____Phone #_____Relationship_____ Primary Care Physician / Family Doctor(s)_____ Are you currently under the care of a Home Health Agency?____ No____ Yes, name of Co._____
How did you hear about FYZICAL?_____

Insurance Information

Medicare #_____ Part B effective date_____ Insurance Policy #_____Group #:_____ Policyholder's Name: _____Relation to Patient:_____ DOB:_____

Insurance Address (if other than above):_____

If Patient is a minor

Responsible party for bill if other thanpatient:_____Relationship:_____
Responsible party's address (if other than above):_____ Date of Birth:_____
Social Security #_____

Consent for Treatment:

I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information:

I authorize FYZICAL to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and_____

Consent to Obtain Medical Information:

I authorize FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to FYZICAL.

Guarantee of Payment:

I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature: _____Date:_____