Patient Registration Form

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.

Patient Information		
Last Name	**First Name**	**Middle**
Mail Address		**Apt/Condo #**
City	**State**	**Zip**
Home Phone	**Cell Phone**	**Email**
Preferred Method of contact for appointment reminders and other electronically generated messages. Circle all that apply Text Voice Email		
Date of Birth / /	**Gender (at birth)** ◯ Female ◯ Male	**Preferred Pronouns**
Marital Status Single Married Widowed Other	**Employer's Name**	**Occupation**
Related Cause to why you are being seen in our office ◯ Work Injury ◯ Auto Accident ◯ Surgery ◯ Other		**Injury Date or Surgery Date** / /
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**
Guarantor or Legal Guardian Information		
Last Name	**First Name**	**Date of Birth** / /
Mailing Address ◯ Check if same as patient	**Relationship to Patient**	**Employer's Name**

1. Is the patient receiving home health services currently ◯ Yes ◯ No
2. Has the patient received home health services in the past 30 days? ◯ Yes ◯ No
3. Is the patient receiving physical, occupational, or speech therapy services elsewhere? (even for a non-related diagnosis) ◯ Yes ◯ No

By signing below, the patient and/or guarantor confirms all the information provided is accurate, current and valid.

_____ ____/____/____

Patient or Legal Guardian's Signature Date

Patient Consent & Financial Agreement

_____
Patient or Legal Guardian's Printed Name

General Consents and Acknowledgements

1. I consent and hereby authorize FYZICAL Therapy & Balance Centers (FYZICAL), through its appropriate personnel, agents, and affiliates to perform the evaluation, care and treatment procedures that are deemed necessary by my physician(s) and other healthcare providers, or by my physical therapist via direct access (collectively my "Care"). I understand that no warranties or guaranties have been made about the outcome of my Care. I 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 from liability now and in the future.
2. I understand that FYZICAL works with accredited academic institutions, through clinical student affiliations, to provide healthcare professionals in training with hands-on patient care experiences and opportunities to apply learned skills to actual patient care. I understand that such healthcare professionals in training may be involved in my Care.
3. I authorize payment of medical benefits to FYZICAL and its affiliates.
4. It is understood and agreed that FYZICAL is not responsible for loss or damage or theft of any personal valuables or properties, and hereby release FYZICAL from any responsibility and/or liability for the loss, damage, or theft of any of my personal property at or in the vicinity of any FYZICAL location.
5. I understand that I am not permitted to take pictures or make video or audio recordings at any FYZICAL location or clinic or of my care, other patients or FYZICAL personnel.
6. I, the undersigned, agree to be responsible for all deductibles, coinsurance, and non-covered portions of services performed. I understand that all co-payments, coinsurance, and deductibles are due at time of service. I understand that benefits quoted to me are only an estimate. I understand that FYZICAL is not responsible for any inaccurate information they receive from my insurance. I understand that it is my responsibility to know and understand my health plan. I understand that FYZICAL and its affiliates bill insurance companies as a courtesy. I understand that it is my responsibility to obtain necessary referrals from my doctor prior to coming to FYZICAL. Should my account be referred to an agency or attorney for collections, I agree to pay all attorney and collection fees charged to FYZICAL associated with collecting the debt. I agree to pay an insufficient funds fee for any returned checks.
7. I understand that to ensure that patient inquiries are handled accurately, some of the phone calls between FYZICAL (or any of its affiliates, agents, assigns, and service providers) and me (or anyone who is authorized to speak with FYZICAL on my behalf) may be monitored and/or recorded.
8. I understand and consent to FYZICAL's use of email communication for clinic announcements and marketing related campaigns. In providing our team with your email, you grant us permission to communication with you through this medium. You will be provided with the ability to opt-out of communications on all email footers.

My signature below acknowledges the above consent and agrees to the terms in its entirety.

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 Practice and do not want a paper copy currently. You may request a copy of the Notice and/or ask any questions about the Notice at any time.

My signature below acknowledges the above consent and agrees to the terms in its entirety.

_____ ____/____/_____
Patient or Legal Guardian's Signature Date

_____
Patient or Legal Guardian's Printed Name

Cancellation Policy

At FYZICAL, we know during your treatment you may need to cancel or reschedule an appointment. However, 24-hour notice is required so we can utilize the time for another patient. When you cancel under 24 hours, it not only impacts your care plan and your Physical Therapist's schedule, but it also takes away an appointment from other patients waiting for treatment.

I, the undersigned, understand and acknowledge that my appointments are scheduled according to professional staff availabilit y. I understand that my appointment may be rescheduled by FYZICAL if I arrive more than 15 minutes late. I also acknowledge that FYZICAL requires 24 hours advance notice of cancellation and that FYZICAL reserves the right to charge a cancellation fee if I fail to cancel an appointment at least 24 hours in advance. I understand that FYZICAL also reserves the right to remove future appointments if I am unable to provide the 24-hour notice on a reoccurring cadence.
My signature below acknowledges the above consent and agrees to the terms in its entirety.

Communication Consent

As part of our commitment to provide you with the best care, FYZICAL may need to communicate via text, email and phone calls for purposes like appointment reminders, health updates, and treatment options.

I consent to receiving text messages for medical and administrative purposes, including appointment reminders. I understand that standard text messaging rates may apply, and I can withdraw this consent at any time.
I consent to receiving emails for medical and administrative purposes, including appointment reminders. I understand that email communication may not be encrypted, and I can withdraw this consent at any time.
I consent to receiving phone calls for medical and administrative purposes, including appointment reminders. I understand that this may include calls made by an automated dialing system and/or pre-recorded messages, and I can withdraw this consent at any time.
My signature below acknowledges the above consent and agrees to the terms in its entirety.

_____ ____/____/_____
Patient or Legal Guardian's Signature Date

_____
Patient or Legal Guardian's Printed Name

Consent for Discussion

I _____, hereby give consent to FYZICAL to discuss my health treatment with the following designated individual (s):

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

The scope of discussion may include medical condition and treatment options, appointment scheduling and reminders, billing and payment matters. I understand that I have the right to revoke this consent at any time by providing a written notice to FYZICAL. My signature below acknowledges the above consent and agrees to the terms in its entirety.

Credit Card/Debit Card Payments

By signing this form, I authorize FYZICAL and its affiliates to keep my credit card on file for future payments. You have the option to decline this convenience and physically produce your card at every visit. If you would like to decline this option, please initial here_____.

My signature below acknowledges the above consent and agrees to the terms in its entirety.

_____ ___/___/____
Patient or Legal Guardian's Signature Date

FYZICAL Therapy & Balance Centers

Patient Health Questionnaire

Patient Information		
Patient Name	**Age**	**Date / /**

Describe your current complaint or limitation:		
Describe how your condition began:		
How long ago did your condition start:		
List tests or other inventions you have had for this condition:		
Indicate the daily activities that you cannot perform:		
Are there any environmental or living conditions that you have difficulties with:		
Level of Function prior to onset:	**Surgery: Y N date: / /**	**Procedure:**

Please describe the nature of your symptoms (check all that apply):

☐ Vertigo	☐ Sudden change in hearing	☐ Constant (76-100%)
☐ Lightheadedness	☐ Sharp Pain	☐ Frequent (51-75%)
☐ Imbalance	☐ Dull (Pain) Ache	☐ Occasional (26-50%)
☐ Feeling "off"	☐ Throbbing	☐ Intermittent (25% or less)
☐ Ear Pressure/Pain	☐ Numbness	
☐ Motion intolerant	☐ Shooting	
☐ Migraine/headaches	☐ Burning	
☐ Head Injury/ Concussion	☐ Tingling	
☐ Tinnitus (ear ringing)		

Level of symptoms at rest: 0 (none) to 10 (unbearable)	**Level of symptoms with activity:** 0 (none) to 10 (unbearable)
Since your condition began 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 ☐ Y ☐ N**

Weight:	**Height: ___ft ___in**
Have you fallen in the last year? ☐ Y ☐ N If yes, how many falls?	**If you fell, did you have an injury? ☐ Y ☐ N** Type of injury:
Have you ever been diagnosed with a concussion? ☐ Y ☐ N	**Are you Diabetic? ☐ Y ☐ N**
Have you ever been involved in a motor vehicle accident or have had trauma to your neck? ☐ Y ☐ N If yes, when?	
Do you use tobacco products? ☐ Y ☐ N If yes, packs/day?	**Hospitalization/ Surgical Procedures:**
Pain 0 (no symptoms) to 10 (unbearable symptoms) Current: _____Best:_____Worst:	

FYZICAL Therapy & Balance Centers

Patient Health Questionnaire Cont.

Patient Name	Date / /

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	Past	Present	Condition
☐	☐	High Blood Pressure	☐	☐	Hepatitis
☐	☐	Angina	☐	☐	Epilepsy
☐	☐	Heart Attack	☐	☐	Rheumatoid Arthritis
☐	☐	Stroke	☐	☐	Arthritis
☐	☐	COPD	☐	☐	Osteoporosis
☐	☐	Asthma	☐	☐	Joint Replacement
☐	☐	HIV/AIDS	☐	☐	Pregnancy
☐	☐	Cancer Location:_____Date:	☐	☐	Drug or Alcohol Dependence
☐	☐	Tumor	☐	☐	Hearing Loss
☐	☐	Systemic Lupus	☐	☐	Pacemaker/Defibrillator
☐	☐	Other:			

Please fill in the following list of your medications (including supplements and over the counter medications)
If you have your own list, please provide that to the front desk to make a copy, you do not need to fill out this section

Medication	Dosage	Frequency	Route

Pelvic Health Questionnaire ☐ **N/A**	
Describe your current complaint or limitation:	
Describe how long ago your condition started:	
List tests or other interventions you have had for this condition:	
Did you have surgery? ☐ **Y** ☐ **N** 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:	

_____ _____/_____/

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