30 East Padonia Rd, Suite: 104, Lutherville MD 21093
Phone: 410-823-8061 Fax: 443-901-3099

Welcome to FYZICAL Therapy & Balance Centers of Lutherville. We have highly skilled physical therapists Nicole Viscuso, PT, DPT, NCS, Megan Tidey, PT, DPT, Emily Suarez, PT, DPT, NCS, Cassandra Novak, PT, DPT, and Abby Alleman, PT, DPT are waiting to serve you when you arrive for your first visit. They are intent on getting you well and serving you in the highest capacity, now, and in the future!

We have included your new patient forms. Please take your time, and complete them as accurately as possible, as they will help us serve you to the highest level, and to make sure that your first visit is a very meaningful one. To save you time at our office, we highly recommend you fill out the forms in the comfort of your own home. If you would prefer to fill them out in our office, that is perfectly OK. Be sure to arrive an extra 20 minutes prior to your scheduled appointment time, so that your appointment can get started on time.

We want to help you feel comfortable and prepared when we meet you. We recommend that you wear loose comfortable clothing and comfortable shoes.
Also, if you are being seen for BPPV/vertigo, we recommend that you bring a driver with you.

Things you should bring with you:

- Driver's License
- Health Insurance Cards
- Prescription from your physician (if available)

We want to help you in every way we can. As part of that effort, we will call your insurance to verify your insurance benefits. We welcome you to do the same to ensure your benefits are in line with those that we have received.

We look forward to seeing you in our Lutherville office located at:

30 East Padonia Rd. Suite: 104, Lutherville, MD 21093

If for any reason you need to cancel your appointment, you Must call the office before 7:00am the day of your appointment. **There will be a $35 charge for all no-shows, and same day cancels after 7:00 a.m.**

Sincerely,

Joyce Reckley, your FYZICAL Client Care Specialist

FYZICAL Therapy & Balance Centers

PATIENT REGISTRATION

Patient Information

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: ____/____/_____ Age: _____ Gender Assigned at Birth: _____ Marital Status: _____

Social Security Number: _____ - _____ - _____ Email: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Cell # (primary): _____ - _____ - _____ Home #: _____ - _____ - _____

Employer: _____ Work Phone #: _____ - _____ - _____

Reminder Messages: We have an electronic system that can text or email you to remind you of your scheduled appointments. Messages may include billing reminders. Please select below your preferred reminder option:

☐ Text to mobile # _____ ☐ Email _____

PCP Name: _____ **Referring Physician:** _____

How did you hear about us? ☐ Referring Physician ☐ Family/Friends ☐ Social Media ☐ Google/Internet ☐ Other

Who are we authorized to speak with? I authorize ENT Specialty Partners, its affiliated physicians, and affiliated practices to release verbally, electronically, and/or in writing my confidential medical information for purposes of treatment, payment of charges, quality assurance, and utilization review, transfer, and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), any other healthcare providers:

Name: _____ Relation _____ Phone: _____

Name: _____ Relation _____ Phone: _____

******Complete This Section ONLY if Patient is Under 18 Years Old******

Parent/Guarantor Information (Complete if Patient is Under 18 Years Old)

The parent/guardian accompanying the child to the visit is responsible for payment due at the time of service. Our office staff will not get involved in matters involving third party personal billing as the result of custody, court order, or personal circumstances.

Last Name: _____ First Name: _____ Date of Birth: ____/____/_____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone #: _____ - _____ - _____

Cell # (primary): _____ - _____ - _____ Home #: _____ - _____ - _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Spouse Email: _____

****Complete This Section if You Have Medical Insurance****

Primary Medical Insurance

Policy Holder Name: _____
Carrier: _____
Member ID #: _____
Group #: _____
Policy Holder Date of Birth: _____/_____/_____
Relationship to Patient: ☐Self ☐ Parent ☐ Guardian ☐Spouse
Policy Holder Address (if different from patient's address): _____
Policy Holder Phone #: _____

Secondary Medical Insurance

☐ Not Applicable
Policy Holder Name: _____
Carrier: _____
Member ID #: _____
Group #: _____
Policy Holder Date of Birth: _____/_____/_____
Relationship to Patient: ☐Self ☐ Parent ☐ Guardian ☐Spouse
Policy Holder Address (if different from patient's address): _____
Policy Holder Phone #: _____

GUARANTEE OF PAYMENT: If insurance is filed on my behalf for charges associated with care provided by ENT Specialty Partners, its affiliated physicians, and affiliated practices (ESP), I assign to the provider all payments from 1st party, 3rd party, medical, accident, or any other insurance coverage responsible for payment. ESP may use and disclose my healthcare information to an insurance company, 1st party, 3rd party, or accident insurance payor for the purposes of payment if a claim is filed on my behalf. I acknowledge that if ESP submits a claim to my insurance carrier, it is done so as a courtesy and that I am ultimately responsible for all charges incurred unless both parties mutually agree otherwise. I agree that I will pay my estimated out-of-pocket based on the best available information of my current policy, and I understand this is only an estimate. While ESP makes every effort to verify my correct insurance information, I understand ESP cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier. If insurance is filed on my behalf to a plan that is later discovered to be a limited benefit plan or one that restricts the provider's ability to collect from other sources, I understand and agree that the acceptance of that coverage will be rescinded, and the balance will be pursued from the other source. I understand that if paying by check and it is returned or if a credit card dispute is initiated by me or on my behalf, a processing fee will be assessed. The following fees are provided by state: Texas- $30, Maryland - $35, District of Columbia - $25, and Virginia- $50. I attest that the information provided to ESP and written herein is true and accurate.

Disclosures

PRIVACY PRACTICES & PATIENT RIGHTS: By signing this form, I acknowledge that a copy of the company's Notice of Privacy Practices and Patient Bill of Rights has been provided to me for review and is available to take home at my request. I am aware the documents may be downloaded anytime on the company website.

CONSENT TO TREATMENT: By signing this consent form, I voluntarily consent to the administration, treatment and cost of medical services for myself or my dependent. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Patient or Guarantor Signature: _____ **Date:** _____

If Guarantor, Relationship to Patient: _____ **Date:** _____

Please read this Financial Agreement, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Financial Agreement: I understand my insurance is a contract between myself and my insurance company and it is my responsibility to determine if providers are in network with my insurance. ENT Specialty Partners, its affiliated physicians and affiliated practices (ESP) will bill my insurance as a courtesy to me. I understand that I am responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay copayments, coinsurances and/or deductibles at the time of service. ESP may verify my benefits; however, the final determination will be made by my insurance company at the time of payment. Therefore, any estimate for services will be considered an estimate only and any payment will be considered a partial payment only, until such time as the insurance company processes my claim and determines the final out-of-pocket balance that I will owe. The patient/guarantor is ultimately responsible for any balance on their account.

Insurance: We participate in most insurance plans. If the patient is not insured by a plan we are contracted with, payment in full is expected at each visit. If we discover after the visit that insurance did not pay, patient will be required to pay the balance. If insured by a plan we contract with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify active coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Non-covered services: Please be aware that some -and perhaps all– of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will collect payment for these services in full at the time of the visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license (or other government issued identification) and current valid insurance to provide proof of insurance and identity. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly and it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or denies coverage. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If do you not provide active insurance information within 45 days of your visit, the balance will be billed to you.

Forms Fee: Please allow 7-10 business days to complete all forms that require a physical therapist signature and medical review (FMLA, Short-term Disability [STD], or any other leave of absence forms). The physical therapist must review the form, your medical record and complete the form. A fee may be charged and must be paid prior to the completion of the form. Medical Record requests are processed by our billing office staff and fees for the release will be addressed at the time the request is received.

_____(initial) **No Show/Cancellation/Multiple Reschedule Fees:** We are committed to making your appointments at the earliest convenience; therefore, we require a phone call if you are unable to keep your scheduled appointment. Multiple missed appointments may result in our request that you find another specialist. Same day cancellations will be charged $35 if not canceled prior to 7 AM.

Nonpayment. If your account is past due and we have exhausted our standard collection efforts, you may receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless we have agreed to this arrangement. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Collection Fees and Returned Payments: If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law. I understand that if paying by check and it is returned by the bank or by credit card and a dispute is initiated by the cardholder, a processing fee will be assessed depending upon state regulations. In Texas the fee would be $30, $50 in Virginia, $35 in Maryland, and $25 in the District of Columbia.

Collection Efforts: I agree to allow ESP and anyone who collects or communicates on ESP behalf to contact me about my account status, including past due or current charges, using prerecorded calls, text messages, email and calls or messages using live, artificial, or prerecorded voices delivered by an automatic telephone dialing system or any other computer-aided technologies to any landline phone, wireless phone number, other contact number or email address I have provided or that I obtain in the future. I further agree that ESP will treat any email address and phone numbers I provide as my private email or phone number that is not accessible by unauthorized third parties. Unless I notify ESP that my wireless service is based in a different time zone, calls will be made to my cellular device during permitted calling hours based upon the time zone affiliated with the mobile telephone number I provide.

Referrals: If your medical insurance plan requires a referral for specialist services, you **will** need the referral from your Primary Care Physician prior to seeing our Specialist. If the referral is generated from the insurance company, you must contact your Primary Care Physician and ensure they contact your insurance to complete this requirement. As a Specialist, our staff cannot generate a referral on your behalf. If your referral is not received prior to your appointment, you will need to reschedule or you will be registered as self-pay and will be responsible for all charges. It is the responsibility of the patient to know if a referral is required by their plan and to assure one is approved prior to being seen.

Release of Information: I hereby allow ESP to furnish any information pertaining to my medical treatment to my insurance carrier, attorney, or other providers of service as necessary to obtain payment of services and provide additional care.

Consent for Treatment: I hereby authorize ESP to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary.

Disclosure: During the course of your physician/patient relationship with ENT Specialty Partners, its affiliated physicians and affiliated practices, your physician or others in the practice may refer you to a facility or other service provider where one or more physicians associated with ENT Specialty Partners, its affiliated physicians and affiliated practices may have an investment interest or compensation relationship and therefore may receive directly or indirectly remuneration because of such referral. At the time of such referral, our staff will disclose the existence of any such relationship. You have the right to choose your health care provider and have options of obtaining health care at a facility of your choice. If you have any questions about this disclosure, please do not hesitate to ask one of the physicians listed.

Privacy Practices: ESP is required by law to maintain the privacy of a patient's protected health information (PHI). In addition, we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to PHI. You must list any restrictions on the release of your protected health information on the medical release form. Video or audio recording is strictly prohibited. You acknowledge and consent to receiving notifications and/or electronic communications regarding your healthcare, and understand PHI may be used for marketing purposes in accordance with applicable regulations.

CRISP (Maryland & D.C.): We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug monitoring Program(PDMP), will still be available to providers.

Divorce Decree: This office is NOT a party to your divorce decree. The responsibility for minors rests with the accompanying adult. By signing this document, I certify that I am the legally responsible party that can make medical decision on behalf of the minor. I will be present at each and every appointment unless the a written authorization for someone else to make all necessary medical decisions on behalf of the minor patient is provided to the practice.

Assignment of Benefits & Guarantee of Payment: If insurance is filed on my behalf for charges associated with care provided by ESP, I assign to the provider all payments from 1st party, 3rd party, medical, accident or any other insurance coverage responsible for payment. ESP may use and disclose my healthcare information to an insurance company, 1st party, 3rd party or accident insurance payor for the purposes of payment if a claim is filed on my behalf. I acknowledge that if ESP submits a claim to my insurance carrier, it is done so as a courtesy and that I am ultimately responsible for all charges incurred, unless both parties mutually agree otherwise. I agree that I will pay my estimated out of pocket based on the best available information of my current policy and understand this is only an estimate. While ESP makes every effort to verify my correct insurance information, I understand ESP cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier. If insurance is filed on my behalf to a plan that is later discovered to be a limited benefit plan or one that restricts the provider's ability to collect from other sources, I understand and agree that the acceptance of that coverage will be rescinded, and the balance will be pursued from the other source. I hereby appoint, ESP and any agent acting on its behalf, as my authorized representative to pursue any claims, penalties and administrative and/or legal remedies including appeals to my insurance company, on my behalf for collection against any responsible payer of all benefits due me for the payment of charges associated with my treatment. If I am registering as a self-pay patient, I understand that insurance will not be filed on my behalf, and I agree to pay for all services rendered in full at the time of the visit. I attest that the information provided to ESP and written herein is true and accurate.

I have read and understand this payment policy and agree to abide by its guidelines. My signature below indicates that I have reviewed a copy of the ESP Notice of Privacy Practices, and I have indicated any restrictions on my protected health information below. Scanned signatures suffice as originals.

Patient Signature: _____ **Date:** _____
(or legally responsible person's signature)

Relationship to Patient: _____

FYZICAL®
Therapy & Balance Centers

Medical History Form

If you have ever had a listed condition, please check the box next to it.

Angina/Chest pain	☐	Systemic Lupus	☐
Heart Attack	☐	Osteoarthritis	☐
Cardiac Problems	☐	Osteoporosis	☐
Stroke/TIA	☐	Peripheral neuropathy	☐
Blood clot	☐	Lyme Disease	☐
Asthma / Respiratory	☐	Hepatitis	☐
Emphysema	☐	Diabetes	☐
Epilepsy / seizures	☐	Lower limb swelling	☐
Fibromyalgia	☐	Rheumatoid Arthritis	☐

Other Medical Conditions: _____

Surgical History: _____

_____

Do you have a pacemaker? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No What is your usual BP? _____

Do you have any joint replacements or metal implants? ☐ Yes ☐ No

If yes, please describe: _____

Do you have a history of cancer? ☐ Yes ☐ No

If yes, please describe type and date: _____

Medications:

_____

_____

Recent Imaging:

_____

_____

Patient Signature

_____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact ENT Specialty Partners, its affiliated physicians and affiliated practices Privacy Officer at compliance@entsp.com.

OUR PLEDGE REGARDING MEDICAL INFORMATION

At ENT Specialty Partners, its affiliated physicians and affiliated practices, we are committed to keeping your health information private and secure as mandated by the law known as the Health Insurance Portability and Accountability Act (HIPAA). You can trust that we will always inform you about our legal responsibilities and how we protect your privacy.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bill, to support the operation of ENT Specialty Partners, its affiliated physicians and affiliated practices, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician whom you have been referred by ENT Specialty Partners, its affiliated physicians and affiliated practices to ensure that the physician has the necessary information to diagnosis and treat you.

Payment

Your protected health information will be used, as needed to obtain payment for your health care services. However, we will agree with any request you make regarding the restriction on the disclosure of your PHI to a health plan if the disclosure is for the purpose of payment and you have paid for the item or service out-of-pocket and in full.

Health Care Operations

We may use or disclose, as-needed, your protected health information in order to support the business activities of ENT Specialty Partners, its affiliated physicians and affiliated practices. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging of other business activities. In addition, we may call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. However, we will agree with any request you make regarding the restriction on the disclosure of your PHI for healthcare operations.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law,

Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security and Workers' Compensation.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Scanned and faxed signatures will suffice as the original. Uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI can be made only with your authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Right to Inspect and Copy

You have the right to inspect and receive a copy of medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. To inspect or receive a copy of your medical information, you must submit your request in writing to ENT Specialty Partners, its affiliated physicians and affiliated practices. You may be charged reasonable administrative fees.

Right to Amend

If you feel that medical information we have about you is incorrect you may ask to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing and submitted to ENT Specialty Partners, its affiliated physicians and affiliated practices. You must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- Is not part of the medical information kept by ENT Specialty Partners, its affiliated physicians and affiliated practices;

- Is not part of the information which you would be permitted to inspect and copy; or

- Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made for purposes other than treatment, payment, or healthcare operations or pursuant to your authorization. To request this list or accounting of disclosures, you must submit your request in writing to ENT Specialty Partners, its affiliated physicians and affiliated practices. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. You have the right to be notified when a breach of your unsecured PHI has occurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member, friend or other responsible party.

We are not required to agree to your request. If we do agree, we will comply with your request unless

the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to ENT Specialty Partners, its affiliated physicians and affiliated practices. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Right to Opt Out of Communications
You have the right to opt out of any or all fundraising communications we may send to you regarding products available to you as a patient of ENT Specialty Partners, its affiliated physicians and affiliated practices.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain the effective date. In addition, each time you receive treatment or healthcare services we will make a copy of the current notice available to you.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with ENT Specialty Partners, its affiliated physicians and affiliated practices or with the Department of Health and Human Services. You will not be penalized for filing a complaint. All complaints must be submitted in writing to:

ENT Specialty Partners
Privacy Officer
1212 Corporate Drive, Suite 470
Irving, TX 75038

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this notice or law will be made only with your written permission. If you provide us permission to use or disclose medical information, you may revoke that permission, in writing, at any time, except to the extent that action has been taken in reliance on your permission. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our original records of the care that we provided to you.