30 East Padonia Rd, Suite: 104 Lutherville MD 21093
Phone: 410-823-8061 Fax: 443901-3099

Welcome to FYZICAL Therapy & Balance Centers of Lutherville. We have highly skilled physical therapists Mirasol "Soly" Jacobs, PT, DPT, Nicole Viscuso, PT, DPT, and Lori May-Sachs, PT, 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 for you to complete. 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 30 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 footwear. Also, we ask that you wear a mask.

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**

We do have 3 designated parking spots in the front of our office for you to park in.
They are painted in white with our suite number 104.

Sincerely,

Joyce, your FYZICAL Client Care Specialist

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Therapy & Balance Centers

Name: _____ Date of Birth: _____
Phone Number: _____ Email: _____
Emergency Contact (Name and Phone): _____
How did you hear about us? _____ Occupation _____

Have you fallen in the last year? ☐ Yes ☐ No
How much physical activity or exercise per week? _____
What daily activities are you having difficulty performing? _____
_____
What are your goals for physical therapy?
_____

Do you have difficulty hearing? ☐ Yes ☐ No Do you have hearing aids? ☐ Yes ☐ No

What problem or issue brings you here? _____
How and when did it start? _____
Did you have surgery? ☐ Yes ☐ No Procedure: _____ Date of surgery? _____
What tests have you had? ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Bone scan ☐ Other
Do you have a pacemaker? ☐ Yes ☐ No
Do you have high blood pressure? ☐ Yes ☐ No What is usual BP? _____
Do you have any joint replacements or metal implants? ☐ Yes ☐ No _____

Do you have a history of cancer or tumors? ☐ Yes ☐ No
If yes, please describe type and date: _____

| | |
|---|---|
| Recent night pain or fevers/ sweats | ☐ Yes ☐ No |
| Vision change or double vision | ☐ Yes ☐ No |
| Unintentional weight change | ☐ Yes ☐ No |
| Shortness of breath? | ☐ Yes ☐ No |
| New rashes / psoriasis? | ☐ Yes ☐ No |
| Sleep problems? | ☐ Yes ☐ No |
| Depressed mood? | ☐ Yes ☐ No |
| Anxiety? | ☐ Yes ☐ No |
| Joint swelling? | ☐ Yes ☐ No |
| Nausea, vomiting, bowel or bladder changes? | ☐ Yes ☐ No |

History of tobacco use? ☐ Never ☐ Yes ☐ Quit ☐ Current ☐ Cigarette packs/day
Number of caffeinated drinks per day? _____

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Alcohol use? ☐ Yes ☐ No if Yes, drinks per week?_____

Medical History and Family History. 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. If you have a family history of a condition, check it in the FAMILY column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

| CONDITION | PAST | PRESENT | FAMILY | CONDITION | PAST | PRESENT | FAMILY |
|---|---|---|---|---|---|---|---|
| Angina | ☐ | ☐ | ☐ | Systemic Lupus | ☐ | ☐ | ☐ |
| Chest pain | ☐ | ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | ☐ | Osteoarthritis | ☐ | ☐ | ☐ |
| Cardiac Problems | ☐ | ☐ | ☐ | Osteoporosis | ☐ | ☐ | ☐ |
| Stroke/TIA | ☐ | ☐ | ☐ | Peripheral neuropathy | ☐ | ☐ | ☐ |
| Blood clot | ☐ | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | ☐ |
| Asthma / Respiratory | ☐ | ☐ | ☐ | Hepatitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ | Infectious diseases | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | Epilepsy / seizures | ☐ | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ | ☐ | Lower limb edema/swelling | ☐ | ☐ | ☐ |

Other Present or Past Medical Conditons:_____

Medications- For additional room provide a list medications

Name Reason for taking Dosage

_____

_____

_____

_____

_____

Hospitalization/Surgical Procedures (not described elsewhere):

Type Date

_____

_____

_____

Client Signature _____Date_____

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# Patient Acknowledgement Form

Please Read and Initial:

_____ I consent to **evaluation and treatment** by FYZICAL Therapy and Balance Centers and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ The filling of insurance claims is a courtesy that we extend to our patients. **You will be responsible for any charges not reimbursed or contractually adjusted by your insurance company.** Should your claims not process as you expected or should you have any questions regarding your insurance plan benefits, Please contact your insurance company directly.

_____ I authorize the **release of information** acquired in the course of my treatment including by not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, or other third party payers.

_____I authorize photo and video to be taken when necessary for diagnostic purposes.

_____ I authorize **phone, e-mail, and/or text messages** regarding my treatment and appointments to be left with persons or machines at the phone numbers provided.

_____ I have received and/or been offered a copy of this facility's **Notice of information/ Privacy Practices**.

_____ Medicare beneficiaries have an annual cap for combined therapy services including Physical, Occupational, and Speech Therapies.

_____ Should a patient account become 60 days past due the account will be placed with a collection agency and a $35.00 collection fee will be charged.

_____ I hereby **assign** to FYZICAL Therapy and Balance Centers all payment for medical services rendered to myself or my dependents. **I understand I am responsible for any amount not covered by my insurance.**

_____ **I understand I will be charged a fee of $25.00 for cancelled or missed appointments without 24 hour notice. Payment must be rendered prior to next scheduled visit.**

_____ _____

Patient Signature Today's Date