FYZICAL®

Patient Information

Last Name: _____First Name: _____Middle Initial:_____

Email: _____Address:_____

City:_____State: _____ Zip:_____

Date of Birth:_____Sex:_____Social Security #_____

Home Phone #:_____Work Phone #:_____Cell #:_____

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 ofCo._____

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 than patient:_____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:_____