FYZICAL Therapy & Balance Centers

Patient Registration Form (Formulario de registro de pacientes)

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. (Al rellenar con precisión este formulario en su totalidad y con la escritura legible, tendremos mejor éxito en la facturación de una reclamación limpia a su compañía de seguros.)

Patient Information Información del paciente

Last Name (Apellido)	**First Name** (Nombre)	**Middle** (Segundo)
Mailing Address (Dirección)		**Apt/Condo#** (Apartamento#)
City (Ciudad)	**State** (Estado)	**Zip** (Código postal)
Home Phone (Telefono)	**Cell Phone** (Telefono Cellular)	**Email** (Correo Electronico)
Approved method of contact for appointment reminders and other electronically generated messages. Circle all that apply Método de contacto aprobado para recordatorios de citas y otros mensajes generados electrónicamente. Círculo de todos los que se aplican		
Text (Texto)	Voice (Voce)	Email (Correo Electronico)
Date of Birth (Fecha de Nacimiento) M D Y_	**Gender** (Género) ◯ Female (Mujer) ◯ Male (Hombre)	**Social Security Number** (Número de Seguro Social)
Marital Status (Estado civil) Single Married Widowed Other	**Employer's Name** (Empleador)	**Occupation** (Ocupacion)
Emergency Contact Person (Nombre de Contacto de emergencia)	**Emergency Contact Phone#** (Telefono de emergencia)	**Relationship to Patient:** (Relacion con el paciente)
Related cause to why you are being seen in our office (Causa relacionada por la que lo están viendo en nuestra oficina) ☐ Work Injury ☐ Auto Accident ☐ Surgery ☐ Other		**Injury Date or Surgery Date:** (Fecha de lesion o cirugia) / /
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**

Spouse and or Guardian Information Información del cónyuge or tutor

Last Name (Apellido)	**First Name** (Nombre)	**Date of Birth** (Fecha de Nacimiento) M D Y
Social Security Number (Número de Seguro Social)	**Relationship to Patient:** (Relacion con el paciente)	**Employer's Name** (Empleador)

Is the patient is receiving home health services currently? (¿El paciente recibe actualmente servicios de salud en el hogar?)	YES	NO
Has the patient received home health services in the past 30 days? ¿Ha recibido el paciente servicios de salud en el hogar en los últimos 30 días?	YES	NO
Are you receiving physical therapy services elsewhere? (Even for a non-related diagnosis). ¿Recibe servicios de fisioterapia en otro lugar?	YES	NO

By signing below the patient and/or guarantor is confirming all of the information provided above is accurate, current and valid.
Al firmar a continuación el paciente y / o garante está confirmando que toda la información proporcionada anteriormente es exacta, actual y válida.

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

Patient Consent & Financial Agreement

Authorization for Treatment

Physical therapy services offered at FYZICAL includes, but not limited to evaluation techniques, soft tissue techniques, manual therapy techniques, heat, cold, electrical stimulation, electrical modalities, paraffin, stretching activities, strengthening exercises, cervical/lumbar traction, and the use of gym and/or other fitness equipment.

I have been informed that if any soft tissue technique, particularly Graston technique / active release/ cross-fiber friction mobilization, are used, it may cause bruising and tenderness in the region that is/was treated. If the technique is too uncomfortable, I will bring it to the attention of my physical therapist so that the procedure can be modified or ceased.

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 or in the future.

Assignment of Insurance Benefits and Release of Information

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits; insurance payments be made to FYZICAL and its affiliates. I authorize payment of medical benefits to FYZICAL and its affiliates. **I agree to reimburse FYZICAL for any and all funds that the insurance may send to me directly. I additionally agree to provide the related Explanation of Benefits to FYZICAL, if I'd like any adjustments to be considered.**

Personal Valuables/Dependents/Visitors

It is understood and agreed that FYZICAL is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, if children are present, please keep them off the exercise equipment in order to prevent injuries.

Financial Agreement

I, the undersigned agree, to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that FYZICAL and its affiliates bill insurance companies as a courtesy. I understand that all co-payments, co-insurance, and deductibles are due at the time of service. I understand that benefits quoted to me are only an estimate. I understand that it is my responsibility to know and understand my health plan. I understand that FYZICAL is not responsible for any inaccurate information they receive from my insurance. 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 may be responsible for any and 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.

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. I will be required to sign each receipt approving the charge. 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

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 at this time. You may request a copy of the Notice and/or ask any questions about the Notice at any time.

My signature below is acknowledging the above consent and agreeing to the terms in its entirety.

____ ________ / ________ / ________

Patient or Legal Guardian's Signature Date

Cancellation & No-Show Policy

We strive to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of us at FYZICAL appreciates your adherence and cooperation with this policy. We are here to help you attain all of your goals and optimize your return to all of your highly anticipated activities.

What Is considered a cancellation? An Appointment that Is cancelled less than 24 hours from the appointment time is considered a cancelled appointment. If you are unable to make your appointment, please provide more than a 24-hour notice so that we may offer your appointment time to another patient in need.

What Is considered a No Show? When a patient does not show for a scheduled appointment.

Will I be charged a fee If I cancel less than 24 hours or If I no show for my appointment? There is a penalty that may be assessed. The fee Is not billable to Insurances. The fee will be due on or before the next appointment. To avoidthe fee, see If an earlier or later appointment time is available that day or give more than a 24 hours' notice.

Are there exceptions? Yes! We understand unforeseen things do happen and we most definitely do not want patients coming to an appointment If they are Ill or feel unsafe to drive. A fee will not be charged for certain circumstances, but the occurrence will count towards your cancellation or no-show count.

What happens If I continue to cancel or no show for my appointments? If you cancel your appointment or no show 3 times in a 30-day span, we will place you on a "Same Day Scheduling" option. At that point you will need to call the day you are available to attend therapy to see if we have an opening. No appointments will be made days in advance.

What if I'm going to be late for my appointment? If you are more than 10 minutes late, we may need to modify your appointment time (if we are able to do so) or cancel your appointment in which a fee will be charged.

By signing below, I agree to adhere to the above policy and fully commit to my plan of care so that I can reach my goals!

Patient Signature: ____ Date:______/______/______

FYZICAL®
Therapy & Balance Centers

Client Health Questionnaire

Patient Name: ____ Age: ____________ Date:____/____/_____

Please describe your Current Complaint or Limitation: ____

Please describe how your problem began: ____

Please tell us how long ago your condition started:____

List tests or other interventions for this condition that you have had: ____

Please indicate the daily activities that you cannot perform: ____

Please indicate your level of functioning prior to the onset of this condition:____

Please inform us of any environmental or living conditions that may have difficulties with: ____

Did you have surgery? ☐ No ☐ Yes Date:_____/_____/______ Procedure: ____

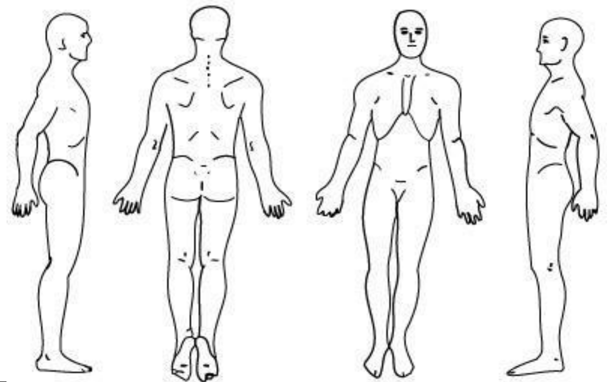
Please describe the nature of your symptoms (check **all** that apply):

- ☐ Vertigo
- ☐ Lightheadedness
- ☐ Imbalance
- ☐ Feeling "off"
- ☐ Ear Pressure/Pain
- ☐ Motion intolerant
- ☐ Migraine/Headaches
- ☐ Head Injury/Concussion
- ☐ Tinnitus (ear ringing)
- ☐ Sudden change in hearing

- ☐ Sharp Pain
- ☐ Dull (Pain) Ache
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

- ☐ Constant (76 – 100%)
- ☐ Frequent (51 – 75%)
- ☐ Occasional (26 – 50%)
- ☐ Intermittent (25% - or less)

Please Mark on the picture locations of pain



Level of symptoms at rest from 0 (No symptoms) to 10 (Unbearable symptoms) __________

Level of symptoms with activity from 0 (None) to 10 (Unbearable) ___________

Since this condition began your 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 ☐ Yes ☐ No

Pelvic Health Questionnaire ☐ **N/A**

Please describe your current compliant or limitation: ____

Please tell us how long ago your condition started: ____

List tests or other interventions for this condition that you have had: ____

Did you have surgery? ☐ Yes ☐ No 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: ____

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	
☐	☐	High Blood Pressure	
☐	☐	Angina	Present: Weight:___________Height:__________ft_________in.
☐	☐	Heart Attack	
☐	☐	Stroke	Have you fallen in the last year? ☐ No ☐ Yes-
☐	☐	Asthma	If yes, how many falls? _______________
☐	☐	HIV/AIDS	If you fell, did you have an injury? ☐ No ☐ Yes
☐	☐	Cancer: Location:_______Date:________	Type of Injury: _______________________
☐	☐	Tumor	Are you diabetic? ☐ No ☐ Yes
☐	☐	Systemic Lupus/	
☐	☐	Hepatitis	Do you use tobacco products? ☐ No ☐ Yes
☐	☐	Epilepsy	If yes, packs/day?_____/_____
☐	☐	Rheumatoid Arthritis	Pain 0 (no symptoms) to 10 (unbearable symptoms):
☐	☐	Arthritis	Current:_________ Best:_________Worst: _________
☐	☐	Pregnancy	
☐	☐	Drug or Alcohol Dependence	Hospitalization/Surgical Procedures
☐	☐	Hearing Loss	(list if not described elsewhere):_______________________
☐	☐	Pace Maker	
☐	☐	Other ____________	____

Please fill in the following list of your medications (including supplements and over the counter medications)

Medication Name	Dosage	Frequency	Route

____ _____/_____/_____________

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

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT REGARDING CONCURRENT HOME HEALTH CARE SERVICES

Purpose:

This Agreement sets forth the terms under which the Patient agrees to be financially responsible for charges incurred for outpatient physical therapy services in situations where such services are denied by the Patient's insurance due to concurrent receipt of home health services.

1. Understanding of Insurance Limitations

The Patient acknowledges and understands that Medicare and most insurance providers will NOT cover outpatient physical therapy services at FYZICAL, if the Patient is receiving any form of home health care services simultaneously.

If a patient is receiving home health care services, they are considered home bound and not eligible for outpatient physical therapy coverage under most insurances.

This is typically demanded in the form of repayment from FYZICAL to the insurance company AFTER initial payments have been made for the patients outpatient physical therapy services and upon the insurance company determining that both outpatient and home health care services were provided simultaneously.

These home health care services may include, but are not limited to, nursing care, physical therapy, occupational therapy, or speech therapy delivered in the home setting for any condition that's related or non-related to the condition treated in outpatient physical therapy.

2. Patient Obligation to Disclose Home Health Services

- The Patient agrees to promptly notify FYZICAL **BEFORE** their initial outpatient physical therapy first visit evaluation, if they are under any form of home health care services and without [written] evidence of Patient being discharged from ALL home health care services if applicable.
- The Patient also agrees to promptly notify FYZICAL **BEFORE** their next scheduled visit with FYZICAL, if any of their medical providers initiated any type of home health care service at any point **DURING** the course of their outpatient physical therapy treatment.
- This notification by the patient to FYZICAL must be made immediately and therefore timely upon the initiation of any home health care service in order to avoid any insurance denial and/or repayment of concurrent outpatient physical therapy services by FYZICAL to any insurance provider.

3. Financial Responsibility

If the Patient fails to notify FYZICAL of concurrent home health care services and the Patient's insurance provider denies coverage through their demand for repayment for outpatient physical therapy services by FYZICAL due to the overlap, the Patient agrees to be fully and personally responsible for all charges associated with the denied services. This includes, but is not limited to, charges for evaluations, treatments, and any other related services provided by FYZICAL.

4. No Waiver of Charges

FYZICAL is under no obligation to waive any charges resulting from denied claims due to undisclosed concurrent home health care services. FYZICAL is not responsible nor has the capacity to track all of the patient's medical providers and their prescribed medical care and this is the sole responsibility of the Patient. The Patient agrees that failure to timely disclose such home health care services to FYZICAL is a breach of this Agreement and shall not constitute grounds for dispute or appeal against FYZICAL for reimbursement or debt forgiveness.

5. Entire Agreement

This Agreement constitutes the entire understanding between the parties with respect to the subject matter herein and supersedes all prior discussions, agreements, or understandings of any kind.

6. Amendments

No amendment or modification of this Agreement shall be effective unless made in writing and signed by both the Patient and the Provider.

7. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the STATE OF FLORIDA in which the Provider operates.

Patient Signature: ____________________________ Date: _______________