FYZICAL
Therapy & Balance Centers

Patient Referral / Intake Forms

Appointment Date:_____ Time:_____ Therapist:_____

Patient's Name:_____ M F Date:_____
Email Address:_____ Marital Status: M S D W
Home Address:_____
DOB:_____ Contact :(H)_____ (M)_____
Ref Phys:_____ Script: Y N Date:_____
Diagnosis:_____ ICD10:_____
Post-Surgical: Y N Date: Stroke?: Y N Date:
Emergency Contact: Phone#: Relationship:

If patient is a minor:
Responsible party for bill of other than patient:_____Relationship:_____
Responsible party's address (if other than above):_____
Date of Birth:_____Social Security #:_____

Have you been to us before? Y N
How did you hear about us: DR / WI / CI / INS / Newsletter / Other:_____Spanish / Creole
Have you had Physical and/or Occupational and/or Speech Therapy within the past 12 months? Y N
Mo/Yr:_____Condition:_____Approx # of visits used:_____
Have you had Physical Therapy in the past for this problem? Y N
Have you had any diagnostic tests related to this problem? (ie. MRI or X-Ray)
Please specify Where and When:_____

Have you received Home Health Care or Hospice Services within the past 12 months? Y N
Name of Home Health Agency:_____ Phone#:_____
Discharge Date:_____Spoke with:_____

Are you being treated for injuries sustained from an Auto Accident, a Slip and Fall OR Work Related Injury? Y N
If Yes: WHEN? _____HOW? _____WHERE?_____
Employer's name, address, and phone #:_____

Are you currently working?___Y___N___If Yes: How many hours a week?_____
What is your Occupation?_____

Are you taking any medications? Y N If yes: Please bring a list of all medications to your first visit.

I have read and reviewed the information herein and represent that the same is true, correct, and complete. I understand that FYZICAL and its health practitioners are relying upon the information in rendering treatment.

Signature:_____ **Date:**_____

FYZICAL
Therapy & Balance Centers

Patient Initials: _____

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), physicians 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, legal fees and collect agency fees.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature: _____Date: _____

FYZICAL
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Patient Initials: _____

NOTICE OF PATIENT INFORMATION PRACTICES-

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

FYZICAL™ LEGAL DUTY

FYZICAL™ is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

FYZICAL™ uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, FYZICAL™ may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you. FYZICAL™ may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law. In any other situation, FYZICAL™ policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. FYZICAL™ may change its policy at the time. When changes are made, a new Notice of Information Practices at any time.

CONCERNS AND COMPLAINTS

If you are concerned that FYZICAL™ may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPPA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on FYZICAL™ health information practices, or if you have a complaint, please contact the following office:

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Signature: _____Date: _____

FYZICAL
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Patient Initials: _____

Please read and sign.

As a courtesy, FYZICAL™ can call and check on your insurance benefits for physical therapy. As the insurance company states, the information given to us is not a guarantee of coverage or benefits. It is ultimately the patient's responsibility to know his/her insurance policy (for example: deductibles, coinsurance, co-payments, if referrals or pre-authorizations are required, what is covered and what is not covered by his/her plan).

To our Medicare patients: Medicare pays 80% of allowed charges after the annual deductible has been satisfied. The 20% coinsurance is billed to the patient unless there is a secondary/supplemental insurance. If there are benefits for physical therapy, the claim will be processed according to the patient's insurance policy/contract.

If there is a patient responsibility after the insurance processes the claim or if there is no insurance, the patient is held responsible for the balance. FYZICAL™ accepts cash, checks, Visa, MasterCard and Discover.
This is not a guarantee of coverage of benefits. You are responsible for payment.

Here at FYZICAL™, we strive to give you the attention you require. Please understand that scheduled appointment times are an important factor and your courtesy of cancellation is much appreciated. We do know that there are exceptions when circumstances arise that are beyond your control that require you to cancel. **We reserve the right to charge a $50.00 fee for a no-show appointment or a cancellation without a 24-hour notice. This fee is your responsibility and is not a billable charge to your insurance.**

I have read and understand the above.

_____ _____

Patient's Signature **Date**

FYZICAL Therapy & Balance Centers

Patient Initials: _____

CLIENT NEEDS SURVEY

1. Have you had a fall in the past year?	YES ◯	NO ◯
2. Do you have a fear of falling?	YES ◯	NO ◯
3. Would you like your balance to be assessed?	YES ◯	NO ◯
4. Do you experience dizziness or imbalance?	YES ◯	NO ◯
5. Do you lose your balance when stepping up/down curbs or stairs/steps?	YES ◯	NO ◯
6. Do you have a difficult time walking in the dark?	YES ◯	NO ◯
7. Do you have difficulty hearing?	YES ◯	NO ◯
8. Do you have osteoporosis, osteoarthritis and/or joint pain?	YES ◯	NO ◯
9. Do you take bone and/or joint supplements?	YES ◯	NO ◯
10. Do you experience muscle aches, pains and/or muscle cramping?	YES ◯	NO ◯
11. Do you use cold, heat or compression therapy at home?	YES ◯	NO ◯
12. Are you interested in learning how compression clothing with ice could help your condition?	YES ◯	NO ◯
13. Are you interested in learning how home heat and/or cold therapy could help your condition?	YES ◯	NO ◯
14. Do you have foot and/or ankle pain/discomfort?	YES ◯	NO ◯
15. Do you currently wear shoe inserts?	YES ◯	NO ◯
16. Are you interested in learning about how a shoe insert could help your condition?	YES ◯	NO ◯
17. Do you have pain and/or physical challenges other than what you are being seen for today?	YES ◯	NO ◯
18. Would you like to get more information about your whole-body health?	YES ◯	NO ◯
19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	YES ◯	NO ◯

FYZICAL Therapy & Balance Centers

Patient Initials: _____

Please rate your pain from 0 (no pain) to 10 (worst imaginable pain) at:

WORST	0	1	2	3	4	5	6	7	8	9	10
NOW	0	1	2	3	4	5	6	7	8	9	10
BEST	0	1	2	3	4	5	6	7	8	9	10

Date of injury onset: _____

What initially caused your pain:

_____

_____

PAST MEDICAL HISTORY

Do you have, or have you had, any of the following? (Please circle all that apply)

- ☐ Anemia
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer
- ☐ Depression
- ☐ Disc Problems
- ☐ Dizziness / Fainting
- ☐ Excessive Fatigue
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Infectious Disease
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Metal Implants
- ☐ Neck Pain
- ☐ Open Wounds
- ☐ Osteoporosis
- ☐ Perforated Ear Drums
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Skin Rashes
- ☐ Stroke
- ☐ Tingling In Arms / Hands
- ☐ Typhoid/Cholera/Dysentry
- ☐ Other Health Issues (Please Explain)
- ☐ Allergies
- ☐ Balance
- ☐ Bowel / Bladder Issues (Incontinence)
- ☐ Chest Pains
- ☐ Diabetes
- ☐ Headaches
- ☐ Epilepsy
- ☐ Fever, Higher than 100 Degrees F
- ☐ Heart Disease
- ☐ Hypoglycemia
- ☐ Knee Pain
- ☐ Liver / Gallbladder Problems
- ☐ Low Exercise Level
- ☐ Nausea / Vomiting
- ☐ Neck Stiffness
- ☐ Osteoarthritis
- ☐ Pacemaker or Defibrillator
- ☐ Radiation Treatment within last 3 mos.
- ☐ Ringing in Ears
- ☐ Shortness of Breath/Difficulty Breathing
- ☐ Stomach or Intestinal Issues
- ☐ Thyroid Problems
- ☐ Tingling in Legs / Feet
- ☐ Vision Problems

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Cancellation / No Show Policy:

Patient Name: _____ Physical Therapist Name: _____

- Please be aware that any patient that is scheduled on a particular day who cancels their appointment on the same day of that said appointment is subject to a **$50.00 charge**.

******To not disrupt the frequency of appointments planned by your therapist, the $50.00 charge will be dismissed If the appointment is rescheduled within the same week ******

- (Please be aware cancelling an appointment scheduled on a Friday does not allow the opportunity for the charge to be dismissed.)

Patient Initials: _____ FYZICAL Staff Initial: _____

- Also, be aware that any patient that is scheduled on a particular day that does not show up for their appointment
and does not inform FYZICAL Therapy & Balance Centers that they do not plan to attend said appointment is subject to a **$50.00 charge and any upcoming appointments already scheduled will be removed.**

******No-Shows do not have the option for the $50.00 charge to be dismissed******

Patient Initials: _____ FYZICAL Staff Initials: _____

- I, _____, understand that if I have incurred a Cancellation or No-Show charge, that I **must pay the charge prior** to being seen again at FYZICAL Therapy & Balance Centers.

Patient Initials: _____ FYZICAL Staff Initials: _____

Patient Signature: _____

FYZICAL Staff Signature: _____