



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 Celular)	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) <input type="radio"/> Female (Mujer) <input type="radio"/> 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) <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Surgery <input type="checkbox"/> Other		Injury Date or Surgery Date: (Fecha de lesion o cirugía) / /
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 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 appreciate 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 avoid the 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: ____/____/____

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: _____

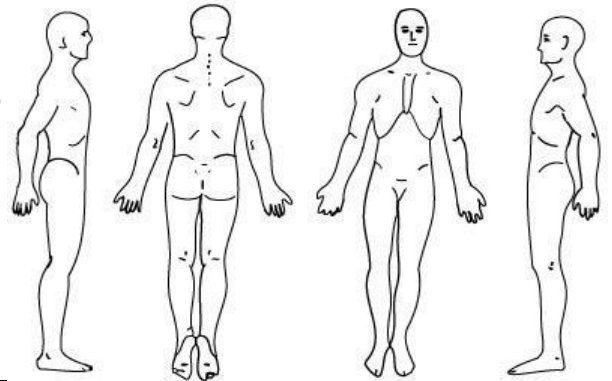
Please inform us of any environmental or living conditions that may have difficulties with: _____

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

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Constant (76 – 100%) |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Dull (Pain) Ache | <input type="checkbox"/> Frequent (51 – 75%) |
| <input type="checkbox"/> Imbalance | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Occasional (26 – 50%) |
| <input type="checkbox"/> Feeling “off” | <input type="checkbox"/> Numbness | <input type="checkbox"/> Intermittent (25% - or less) |
| <input type="checkbox"/> Ear Pressure/Pain | <input type="checkbox"/> Shooting | |
| <input type="checkbox"/> Motion intolerant | <input type="checkbox"/> Burning | |
| <input type="checkbox"/> Migraine/Headaches | <input type="checkbox"/> Tingling | |
| <input type="checkbox"/> Head Injury/Concussion | | |
| <input type="checkbox"/> Tinnitus (ear ringing) | | |
| <input type="checkbox"/> Sudden change in hearing | | |

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 complaint 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	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Angina	Present: Weight: _____ Height: _____ ft _____ in.
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	Have you fallen in the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes-
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	If yes, how many falls? _____
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	If you fell, did you have an injury? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	Cancer: Location: _____ Date: _____	Type of Injury: _____
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	Are you diabetic? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus/	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	Do you use tobacco products? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	If yes, packs/day? _____/_____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	Pain 0 (no symptoms) to 10 (unbearable symptoms):
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	Current: _____ Best: _____ Worst: _____
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence	Hospitalization/Surgical Procedures
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	(list if not described elsewhere): _____
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	_____
<input type="checkbox"/>	<input type="checkbox"/>	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



MEDIA RELEASE CONSENT FORM

I _____ hereby consent and authorize an employee or agent of **FYZICAL Therapy & Balance Centers** to take photographs or motion pictures of me; or to produce videotapes, audiotapes, closed circuit television programs, web casts, or other types of media productions that capture my name, voice, and/or image (any of the foregoing types of media are called the "Materials" in this Consent and Release form).

I authorize **FYZICAL Therapy & Balance Centers** to copyright the materials, and I authorize **FYZICAL Therapy & Balance Centers** to use, reuse, copy, publish, display, exhibit, reproduce, license to a third party, and distribute the materials in any educational or promotional materials or other forms of media, which may include, but are not limited to publications, catalogs, articles, magazines, recruiting brochures, websites or other electronic forms of media, and to offer the materials for use or distribution in other publications, electronic or otherwise, without notifying me.

I also agree that **FYZICAL Therapy & Balance Centers** may identify me by name, and such other identifying information such as current hometown and state.

I agree that I am participating on a voluntary basis and I will not receive any payment from **FYZICAL Therapy & Balance Centers** for signing this release or as a result of any publication of the materials.

Signature

Date: _____

Print Name

Address

(To be signed if the person in the materials is under the age of 19.)

I am the parent or guardian of the person whose image appears in the materials and I give my authorization and consent on his/her behalf.

Name

Date: _____

Print Name

Address