FYZICAL®
Therapy & Balance Centers

Patient Intake Questionnaire

NAME:_____DATE OF BIRTH:_____

ADDRESS: _____

CITY:_____STATE:_____ZIP CODE:_____

PHONE #:_____WORK PHONE#:_____

EMAIL:_____OK TO EMAIL: Yes___No___

PRIMARY INSURANCE: _____

SECONDARY INSURANCE:_____

EMERGENCY CONTACT– NAME:_____
PHONE #:_____RELATIONSHIP_____
PRIMARY CARE PHYSICIAN:_____

CONSENT FOR TREATMENT: I hereby consent to receive care for therapy services by FYZICAL™. I consent to medical treatment as is deemed necessary or advised by the physical therapist.

LIABILITY RELEASE: I hereby accept the responsibility for any harm, injury, or damage that may result from my participation in physical therapy services. I hereby waive, release, absolve, indemnify, and agree to hold harmless FYZICAL THERAPY & BALANCE CENTERS; its officers, employees, students and affiliates for any claim arising out of any injury to me, whether the result of negligence or any cause. I voluntarily and knowingly acknowledge, accept and assume these risks.

ASSIGMENT OF INSURANCE BENEFITS & RELEASE OF MEDICAL INFORMATION: I authorize FYZICAL[tm] to release any information acquired in connection with my therapy services including but not limited to diagnosis, clinical records, to myself, my insurance claims to aid in processing, physician, and _____.

I also request/authorize payment of government benefits/insurance payments be made to FYZICAL and its affiliates.

CONSENT TO OBTAIN MEDICAL INFORMATION: I authorize FYZICAL[tm] to obtain and acquire medical information that would be beneficial in connection to my therapy services including but not limited to x-rays, MRI, CAT scans, and physicians records.

NOTICE OF PRIVACY PRACTICES/ HIPAA: I have read and understand my rights under the Health Insurance Portability and Accountability Act.

****IF MINOR:** Responsible party:_____Relationship:_____

I HEREBY CERTIFY THAT I UNDERSTAND THESE RIGHTS AS SET FORTH.

Patient/ Responsible Party Signature:_____

Date:_____

PATIENT NAME:

INSURANCE NOTICE:

I ACKNOWLEDGE FYZICAL THERAPY & BALANCE CENTERS HAS CONTACTED MY INSURANCE COMPANY ON MY BEHALF AND MADE AN EARNEST EFFORT TO ACCURATELY OBTAIN MY INSURANCE BENEFITS. I FURTHER UNDERSTAND THAT THIS INFORMATION HAS BEEN PROVIDED DIRECTLY BY A REPRESENTATIVE OF MY INSURANCE COMPANY AND THAT FYZICAL CANNOT BE HELD RESPONSIBLE FOR MISINFORMATION GIVEN TO THEM BY MY INSURANCE COMPANY.

I UNDERSTAND THAT IF MISINFORMATION IS GIVEN OUT BY MY INSURANCE COMPANY THAT THE ACTUAL AND TRUE BENEFITS OF MY POLICY WILL BE INDICATED ON MY EXPLANATION OF BENEFITS. I WILL BE RESPONSIBLE FOR THE AMOUNT MY INSURANCE COMPANY STATES IS MY RESPONSIBILITY ON THE EXPLANATION OF BENEFITS.

AMOUNTS DUE ARE ESTIMATES BASED UPON AN AVERAGE FEE SCHEDULE AND THE INFORMATION PROVIDED BY YOUR INSURANCE COMPANY.

FYZICAL
Therapy & Balance Centers

Staff Initials:	
Pat. Initials:	

My benefits as conveyed by my insurance company:

Insurance Company:

Secondary Insurance Company:

Deductible / Portion Met: $

Co-insurance: _____ % **Estimated amount:** per visit.

Co-pay: **Estimated amount:** per visit.

Estimated amount due until deduct met $ per visit.

Payment Recap: **(Estimate)**

Visit Limitations:

Attention all Medicare patients: **Have you had any physical and/ or occupational therapy in 2022 at FYZICAL Therapy and Balance Centers or any other out-patient facility? YES NO**

(Including nursing and therapy services, home health aide, medical supplies, & medical social services)

Patient Signature **Date**

Office Staff Signature **Date**

*****We encourage you to contact your insurance company directly for a full understanding of your benefits*****

Present Condition

What condition or concern has brought you here?_____

Is this condition associated with a surgery?_____If Yes, what and when was the surgery_____

When did this condition begin or recently worsen?_____

Was there a direct cause to this condition?_____

Have you been treated for this condition before?_____If Yes, when?_____

Does this condition affect your daily activities or social life?_____If Yes, please describe_____

_____

What makes it worse_____and What makes it better_____

Are you currently receiving treatment for this condition with another healthcare specialist or physician?_____

If Yes, whom?_____

PLEASE CHECK YOUR PRESENT SYMPTOMS:

__HEADACHE	_MID BACK PAIN	__MUSCLE JERKING	_ANXIETY
__NECK PAIN	_MID BACK STIFFNESS	__MUSCLE SPAMS	_PANIC ATTACKS
__NECK STIFFNESS	_LOW BACK PAIN	__MUSCLE SORENESS	_TENSION
__MEMORY LOSS	_LEG PAIN L / R	__BLURRED VISION	_IRRITABILITY
_SHOULDER PAIN L / R	_LEG TINGLING L / R	__BUZZING/ RINGING IN EARS	_DIFFICULTY SLEEPING
_SHOULDER STIFFNESS	_LEG NUMBNESS L / R	__DIZZINESS	__DIFFICULTY BREATHING
_ARM TINGLING L / R	_BALANCE CONCERNS	__FAINTING	OTHER :
_ARM NUMBNESS L / R	_FATIGUE	__DIFFICULTY BREATHING	

General Health and Past Medical History

re you currently taking any medication or dietary supplements?_____, If Yes, what and for what reason _____

_____

_____

_____

revious operations, hospitalizations, chronic illness, injuries?_____Please describe area of body and when_____

_____

_____

o you smoke_____ If Yes, how many cigarettes a day_____.

o you exercise_____,If Yes, how many times a week_____, how long (mins or hours)_____

n a special diet_____, If Yes, please describe_____

rior to your recent condition, were you participating in any sports, activities or hobbies on a regular basis?_____If Yes, what?___

_____

What goals do you want to achieve through treatment?_____

_____

PLEASE CHECK THE FOLLOWING THAT YOU HAVE OR HAVE HAD:

_ALLERGIES	_COLD HANDS OR FEET	_EPILEPSY	_LUNG DISEASE
_ANEMIA	_CONSTIPATION	_HEART ATTACK	_LOW BLOOD PRESSURE
_ASTHMA	_CURRENTLY PREGNANT	_HEART DISEASE	_METAL IMPLANTS
_CANCER	_DIABETES	_HIGH BLOOD PRESSURE	_NAUSEA
_CHEST PAIN	_DISC PROBLEMS	_KIDNEY PROBLEMS	_OPEN WOUNDS
_CIRCULATORY ISSUES	_EAR DISORDERS	_KIDNEY STONES	_OSTEOARTHRITIS
_OSTEOPOROSIS	_SKIN SENSITIVITY	_THYROID PROBLEMS	_LIVER DISEASE
_RHEUMATOID ARTHRITIS	_STROKE	_BOWEL/ BLADDER ISSUES	_GALLBLADDER PROLEMS
_PACEMAKER	_TUBERCULOSIS	_STOMACH PROBLEMS	_VOMITING
_RADIATION TREATMENT IN LAST 3 MONTHS			
OTHER :			

PLEASE ANSWER YES OR NO FOR THE FOLLOWING:

Have you had a fall in the past year?_____

Do you have a fear of falling?_____

Would you like balance to be assessed?_____

Do you experience dizziness or imbalance_____

Do you lose your balance when stepping up or down curbs or stairs/steps?_____

Do you have a difficult time walking in the dark?_____

Do you have difficulty hearing?_____

Do you have any other concerns that you would like to be addressed while receiving physical therapy?_____

_____

If there is any information you would like us to know about you please feel describe below_____

_____

Thank you for choosing us for your physical therapy needs! We truly look forward to working with you and helping you **LOVE YOUR LIFE.**

FYZICAL®
Therapy & Balance Centers

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? **Yes! The fee is $50 for the first cancel/no show, $75 for second/third cancel/no show.** 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 of $50 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: _____/_____/_____