Patient Registration Form

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.

Patient Information

Last Name	**First Name**	**Middle**
Mailing Address		**Apt/Condo#**
City	**State**	**Zip**
Home Phone	**Cell Phone**	**Email**

Approved method of contact for appointment reminders and other electronically generated messages. Circle all that apply

Text Voice Email

Date of Birth M D Y_	**Gender** ◯Female ◯ Male	**Social Security Number**
Marital Status Single Married Widowed Other	**Employer's Name**	**Occupation**
Emergency Contact Person	**Emergency Contact Phone#**	**Relationship to Patient:**
Reason you are being seen in our office Injury Surgery Fall/Balance Work Related Car Accident Dizziness Wellness		**Injury Date or Surgery Date:** / /
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

Last Name	**First Name**	**Date of Birth** M D Y
Social Security Number	**Relationship to Patient:**	**Employer's Name**

Is the patient is receiving home health services currently? YES NO

Has the patient received home health services in the past 30 days? YES NO

Are you receiving physical therapy services elsewhere? (Even for a non-related diagnosis). YES NO

By signing below the patient and/or guarantor is confirming all of the information provided above is accurate, current and valid.

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 / cupping / 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, coinsurance, 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? A one-time grace appointment will apply, beyond this a $40 fee will be charged. 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/ no-show count on a case-by-case basis.

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 tell us how long ago your condition started:_____

List tests or imaging and dates for this condition that you have had: X-ray_____MRI_____EMG/Nerve Study_____
CT Scan_____ Bone Density Scan_____ Other_____

Please indicate any functional limitations_____

Please specify any specific goals with Physical Therapy_____

Surgery Performed? Y N Type of Procedure_____

Date of Procedure _____

Pain Questionnaire

Pain intensity 0-10 (0 is no pain 10 is intense pain)

At best /10 Currently /10 At worst /10

Describe the Pain/Symptoms_____

What increases the symptoms_____

What decreases the 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 _____	

Do you have any recent unexplained weight loss? Yes No

Do you have any recent changes in bowel or bladder function? Yes No

Do you experience depression and/ or anxiety? Yes No

Do you have any pelvic pain? Yes No

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

Medication Name	Dosage	Frequency	Route

_____ _____/__/ _____

Patient/Legal Guardian Signature **Date**

Dry Needling and Taping Consent Form (Fyzical Rockrimmon)

Dry Needling is an intervention performed by your Physical Therapist in which they have received advanced training and certification to perform. The procedure involves using sterile acupuncture needles that are inserted into the skin. The needles are intended to provide pain relief and facilitate your rehab process by affecting muscle tissue, connective tissue, the nervous system and skeletal system. Although this service is provided by a trained medical professional, there are certain risks and side effects including: bleeding, bruising, redness or localized irritation of the skin, temporary pain/soreness, and pneumothorax. Pneumothorax (lung puncture) is an extremely rare complication with dry needling and special care is taken to avoid this. If any of these complications should occur, your Physical Therapist will provide proper follow up instructions and guide you to further medical treatment as necessary**. Dry needling is not a required intervention with your therapy, and you will be asked to give further verbal consent before dry needling is performed.** There is a **$10 material fee** in addition to any co-pays that is not reimbursable by insurance to have this treatment done during your session.

Please consult with your Physical Therapist with further questions. By signing this form, you are acknowledging that you have read the above information and that there is a $10 fee assessed if dry needling is performed.

Name_____**Sign/Date**_____

Taping is an additional modality that is offered by your Physical Therapist. There are different kinds of tape that we use to improve healing, swelling, joint mechanics, proprioception. Tape can typically be left on for several days and is water resistant. Your Physical Therapist will provide additional information if this modality is performed during your session. **Taping is not a required intervention as part of your therapy. There is a $5 material fee** that will be charged in addition to any co-pays for this service. **By signing below, you acknowledge that you have read the above information and agree to the $5 material fee is taping is performed.**

Name_____ **Sign/Date**_____

Exceptions to these fees apply to certain workers compensation cases, in which a fee will not be applied, but acknowledgement is still required.

Financial Policies & Practice Policies

Welcome to FYZICAL therapy and balance center in Rockrimmon, we are pleased to have you as our patient, and will make every effort to make our services accessible. If at any time you have difficulty making a payment, please discuss this with us. Co-payments and supply fees are due at the time of service. Claims will be submitted to your insurance company. You will be responsible for paying your annual deductible, co-payments, and/or co-insurance.

Insurance

The patient is responsible to make available to the practice, complete insurance information, for accurate filing of claims. This information would include but not limited to referrals from other providers for primary and secondary insurance coverage, all ID, and benefit cards or documentation. The patient agrees that if the insurance company denies benefits for any reason, that he/she is responsible for the full amount of the bill immediately. For services not covered under the patients benefit plan, payment is due at time of service.

PPO & HMO Insurances

If the practice has an agreement with the patient's insurance carrier, we will accept payment from the carrier for services covered by the patient's benefit plan. Deductibles, co-insurance, and co-payments are due at the time services are rendered and collected prior to service is provided.

Indemnity Insurance

Insurance payments received by the practice will be applied to the patients account and the patient agrees to pay the balance. Deductibles, co-insurance, and co-payments are due at the time services are rendered and collected prior to service is provided.

Medicare Insurance

The practice does accept assignment from Medicare. Therefore, the patient agrees to pay the practice the Medicare co-insurance including any amount of the patient's deductible that has not yet been satisfied. Any procedures not covered by Medicare may be due at the time of service. If you have a supplemental policy in which the Medicare carrier automatically sends the claim, we are required to keep a separate signature on file.

X_____ **Date:** _____

Sign name as it appears on the supplement plan insurance card (Medicare patients only). I authorize the practice to release any medical information to my supplemental plan insurance company, for determination of benefits or benefits payable for related services.

Non-Contracted Insurance

The patient must recognize that he/she is responsible to pay the full amount, due at the time of service, unless the practice has an agreement with the patient's insurance carrier for alternative payments. In order to make your visits as pleasurable as possible, the practice will file insurance claims with all standard insurance carriers.

Self-Pay Patients

If you are a self-pay patient, you will be responsible for payment of fees at the time of service. We will not bill insurance for any services provided, however you may submit a super bill for reimbursement from your insurance company.

The cost for self-pay are as follows: Initial evaluation $120, Follow up $90

Returned Checks

If a check is returned, we will not be able to accept that form of payment from you in the future, as well patient will be responsible for the fees that were due at that time.

I have read, understand and agree to comply by the policies listed above.

_____ **x**_____ _____

Printed Name: **Signature of patient or responsible party** **Date**