FYZICAL Therapy & Balance Centers
15201 Shady Grove Road, Suite 106, Rockville, MD 20850 Phone: 301-948-4395 Fax: 301-407-1860

Registration Form

Note: Please print to complete or complete using the fillable option. Paperwork for patients under the age of 18 must be completed and signed by a parent/guardian.

Patient Name (Last, First, Middle Initial): _____ Date of Birth: ____/ ____ /____

Date of Injury: ____/ ____ /____

Cause of Injury (check one): □ Auto Accident □ Workers Compensation □ Other: _____

Age: _____ Sex: Male □ Female □ Marital Status: _____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone #: _____Cell Phone #: _____ Email: _____

Referring Physician: _____ Primary Care Physician: _____

Emergency Contact & Relationship: _____ **Phone #:** _____

Guardian's Full Name (If patient is a minor): _____ Guardian Date of Birth: ____/ ____ /____

Consent for Treatment of a Minor

As a parent and/or legal guardian, I authorize the office/facility to treat the patient while I am not present.

Patient Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Office Policy for No Shows/Cancellations, Returned Checks, and Insurance

We realize circumstances might lead to a missed appointment. However, in order to provide the best care and service to each patient, we ask that you notify us **24-hours in advance** to cancel your appointment. Failure to properly notify the office/facility may result in a fee of $75.00 for the **no show** and/or **late cancellation**. There is also a $25.00 fee for all returned checks.

Insurance is considered a method of reimbursement for patients for fees paid to the doctor/therapist and is not a substitute for payment. Some insurance companies may pay fixed allowances - sometimes referred to as "reasonable and customary fees" - for certain procedures. We do not accept this as payment in full unless otherwise restricted by law or according to the agreement that we may have with your insurer.It is your responsibility as a patient to pay any deductible, co-insurance, or other balance amount not paid by your insurer. In order to manage your cost of billing, we request that charges for visits be paid in full at the onset of the next visit. In the event that the account is turned over for collection, the collection fees and/or legal fees, including attorney fees, shall be your responsibility.

I hereby assign all medical and/or surgical benefits including major medical benefits to which I am entitled (i.e., Medicare, private insurance and other health plans) to the office/facility listed on the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information necessary to secure the payment via fax transmittal or paper copy.

Patient or Parent/Legal Guardian Signature: _____ Date: _____

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Assignment of Benefits

I hereby instruct and direct _____ (insurance company) to pay by check made out and mailed to the office address. If my current policy prohibits direct payment to this practice, I hereby also instruct and direct you to make the check to me and mail it to the office address.

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered, this is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A copy of this assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company or adjuster involved in this case. I authorize FYZICAL Therapy & Balance Centers to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient/Guardian Signature: _____ Date: _____

Notice of Privacy Practices

Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, be kept confidential. This includes the following:

- Treatment
- Payment
- Health Care Operations
- Marketing Activities

A copy of this policy is available to you at your request. In addition, there is a copy displayed in the lobby area of the office/facility to be reviewed.

Patient Signature: _____Date: _____

Informed Consent to Physical Therapy Treatment: I, **_____,**
give consent to physical therapy services provided at FYZICAL Therapy & Balance Center of Rockville to provide and perform physical therapy testing and services as deemed appropriate for my condition. I understand that there are no guarantees regarding a cure for or improvement in my condition. This consent applies to my initial visit and all subsequent visits. Treatment may be delivered through telehealth services, if appropriate. Examination and treatment may involve exposure or palpation of involved areas. I understand that I have the right to decline any portion of treatment at any time or during my treatment session. I understand that this consent may be revoked in writing at any time.

Patient Signature: _____Date: _____

Clinical Information Form

FYZICAL Therapy & Balance Centers

Patient Name_____ *(Please Print)* Date _____/_____/_____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Occupation _____ ☐ Employed (full) ☐ Employed (restricted) ☐ Disability ☐ Retired ☐ Student ☐ Unemployed

Describe your symptoms_____

When did your symptoms first start? _____

How often do you experience your symptoms?

- ☐ Constantly (75-100% of the day)
- ☐ Frequently (50-75% of the day)
- ☐ Intermittently (25-50% of the day)
- ☐ Occasionally (0-25% of the day)

What words best describe your symptoms?

☐ Sharp ☐ Shooting ☐ Burning
☐ Throbbing ☐ Ache ☐ Numb
☐ Tingling ☐ Dull ☐ Tight

Please rate your pain at its worst → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Please rate your pain currently → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Please rate your pain at its best → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

List any positions or activities that **increase** your symptoms _____

List any positions or activities that **decrease** your symptoms _____

Did you have any falls over the past year?
☐ Yes ☐ No *If yes, how many?* ____

Did you have an injury as a result of the fall?
☐ Yes ☐ No

Please check any of the following problems that apply to you:

- ☐ No known significant PMH to affect treatment
- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus Type I
- ☐ Diabetes Mellitus Type II
- ☐ Fibromyalgia
- ☐ Fracture or Suspected Fracture
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Lung Disease
- ☐ Gastrointestinal Disease(Ulcer, Hernia, Reflux, Bowel, Liver, Gall Bladder)
- ☐ Visual Impairments (Cataracts, Glaucoma, Macular Degeneration
- ☐ Hearing Impairment
- ☐ Back Pain
- ☐ Previous Accidents
- ☐ Incontinence
- ☐ Anxiety, Panic Disorders, or Depression
- ☐ Prior Surgery
- ☐ Prosthesis/Implants
- ☐ Sleep Dysfunction
- ☐ Tobacco Use
- ☐ COVID-19
- ☐ Other _____

Height: _____Feet _____Inches **Weight:_____lbs.**

Do you have a pacemaker or defibrillator? Yes No

Patient Goals_____

FYZICAL Therapy & Balance Centers

Current Medications List

Name:_____ DOB: _____/_____/_____

Date Last Updated: _____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

Prescription Medications (Include over-the-counter and supplements):

Name of Medication	Dosage	Frequency	Route Taken (Oral, Injection, topical, etc)	Condition

List Previous Surgeries Date of Surgery

_____

_____

_____

List Previous Surgeries Date of Surgery

_____

_____

_____

Credit Card on file Authorization

Primary Physical Therapy, Inc.

All information will remain confidential.

Patient Name: _____

Name on Card: _____

Billing Zip Code: _____

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Credit Card Number: _____

Expiration Date: _____

CVV Number: _____ (last 3 digits located on the back of the credit card)

I authorize **FYZICAL Therapy & Balance Centers** to charge the above credit card for payments owed to my account for services rendered at their office. I agree to update any information regarding my account. The above information is complete and correct to the best of my knowledge.

_____ _____

Signature Date

This is Non-Negotiable