FYZICAL
Master Healing Factor™

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Would like to receive e-mails on Fyzical events, seminars, and education? Yes ☐ No ☐

Date of Birth: _____ Sex: _____ Social Security # _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Emergency Contact: _____ Phone # _____ Relationship _____

Primary Care Physician / Family Doctor(s) _____

Are you currently under the care of a Home Health Agency? ____No ____Yes, name of Co. _____

How did you hear about Fyzical™? _____

Insurance Information

Medicare # _____ Part B effective date _____

Insurance Policy # _____ Group #: _____

Policyholder's Name: _____ Relation to Patient: _____ DOB: _____

Insurance Address: _____ Phone #: _____

If Patient is a minor

Responsible party for bill if other than patient: _____ Relationship: _____

Responsible party's address (if other than above): _____

Date of Birth: _____ Social Security # _____

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), physician(s), 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, interest fees, legal fees, and collection agency fees.

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

Patient/Responsible Party Signature _____ Date: _____

FYZICAL®

Client Health Questionnaire

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: _____

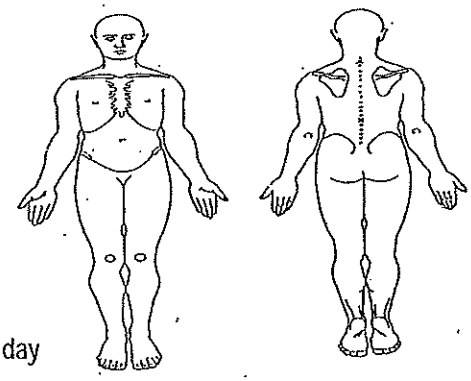
Please inform us of any environmental or living conditions that may have difficulties with: _____

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

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

☐ Vertigo	☐ Sharp Pain	☐ Constant (76 – 100%)
☐ Lightheadedness	☐ Dull (Pain) Ache	☐ Frequent (51 – 75%)
☐ Imbalance	☐ Throbbing	☐ Occasional (26 – 50%)
☐ Feeling "off"	☐ Numbness	☐ Intermittent (25% - or less)
☐ Ear Pressure/Pain	☐ Shooting	
☐ Motion Intolerant	☐ Burning	
☐ Migraine/Headaches	☐ Tingling	
☐ Head Injury/Concussion		

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 (No symptoms) to 10 (Unbearable symptoms) _____
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

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 assist your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure Angina
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Cancer – Location: Date:
☐	☐	Tumor
☐	☐	Systemic Lupus
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Incontinence
☐	☐	Other_____
☐	☐	Tobacco Use – packs/day:
☐	☐	Drug or Alcohol Dependence

Present: Weight _____ Height _____ft _____in.
Have you fallen in the last year? ☐ NO ☐ YES - If yes, how many? _____

Medication: (Name/Dosage/Frequency/Route Administered)

_____

_____

_____

_____

****If you need additional room for medications please bring a separate document on your next visit**

Hospitalization/Surgical Procedures (list if not described elsewhere):

_____

_____

_____

Do you have a Pace Maker: ☐NO ☐YES

FYZICAL THERAPY & BALANCE CENTERS
6000 CATTLERIDGE DRIVE, SUITE 100
SARASOTA, FL 34232

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.

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 and need to cancel. We reserve the right to charge a $25.00 fee for a no-show appointment or a cancellation without 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

Name:_____ Date:_____

The following questionnaires are requirements mandated by CMS for all patients seen here.

Circle the best answer for how you have felt over the past week:

1. **Are you basically satisfied with your life?** Yes No
2. **Have you dropped many of your activities and interests?** Yes No
3. **Do you feel that your life is empty?** Yes No
4. **Do you often get bored?** Yes No
5. **Are you in good spirits most of the time?** Yes No
6. **Are you afraid that something bad is going to happen to you?** Yes No
7. **Do you feel happy most of the time?** Yes No
8. **Do you often feel helpless?** Yes No
9. **Do you prefer to stay at home, rather than going out and doing new things?** Yes No
10. **Do you feel you have more problems with memory than most?** Yes No
11. **Do you think it is wonderful to be alive now?** Yes No
12. **Do you feel pretty worthless the way you are now?** Yes No
13. **Do you feel full of energy?** Yes No
14. **Do you feel that your situation is hopeless?** Yes No
15. **Do you think that most people are better off than you are?** Yes No

If you are age 65 or older, please circle the best answer in response to the questions below:

1. **Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?** Yes No
2. **Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?** Yes No
3. **Have you been upset because someone talked to you in a way that made you feel shamed or threatened?** Yes No
4. **Has anyone tried to force you to sign papers or to use your money against your will?** Yes No
5. **Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?** Yes No

FYZICAL Therapy & Balance Centers
6000 Cattleridge Drive, Suite 100
Sarasota, FL 34232
Phone# 941-378-8977

Name: _____ Date: _____

How Did You Hear About US? (please list all that apply)

If a friend/family member or your doctor told you about us, please let us know so we may thank them.

☐ Friend/Family: _____

☐ Doctor: _____

☐ Fyzical Staff Member: _____

☐ Print Advertisement: _____

☐ Community Event: _____

☐ Radio/TV: _____

☐ Returning Patient ☐ Fyzical Website ☐ Facebook

☐ Internet Search ☐ Reputation ☐ Drive By

☐ Other: _____

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Whether a new or returning client, is there a particular therapist you would like to see? We will do our best to accommodate your request.

Requested Therapist(s): _____

SARASOTA, FL 34232
PHONE (941)378-8977 FAX (941) 378-8967

NOTICE OF PRIVACY PRACTICES SIGNATURE FORM

This signature page is in reference to the New Notice of Privacy Practices.

The undersigned certifies that he/she has read the New Notice of Privacy Practices and is the patient, or is duly authorized by the patient as the patient's representative. If a more detailed explanation is needed, please refer to www.hhs.gov/ocr/privacy or call U.S. Department of Health and Human Services Office at 1-877-696-6775.

The New Notice of Privacy Practices can also be found on our website, www.Fyzical.com.

Print Patient Name_____

_____ _____

Patient Signature (or Patient's Representative) Date

NEW NOTICE OF PRIVACY PRACTICES

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

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

Uses and Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR 164.512 or other applicable laws and regulations, including the following:

To avoid a serious threat to your health or safety or the health or safety of others.

As required by state or federal law such as reporting abuse, neglect or certain other events.

As allowed by workers compensation laws for use in workers compensation proceedings.

For certain public health activities such as reporting certain diseases.

For certain public health oversight activities such as audits, investigations, or licensure actions.

In response to a court order, warrant or subpoena in judicial or administrative proceedings.

For certain specialized government functions such as the military or correctional institutions.

For research purposes if certain conditions are satisfied.

In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

To a member of your family, relative, friend or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclose your religious affiliation to clergy.

To contact you to raise funds for our office. You may opt out of receiving such communications at anytime by notifying the Privacy Officer identified below.

Use and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes, for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.

You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

Changes To This Notice. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying the Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:
Privacy Officer at European Physical Therapy dba Fyzical

6000 Cattleridge Drive, Suite 100, Sarasota. FL 34232 Phone# 941-378-8977

Effective Date. This Notice is effective September 23, 2013.