FYZICAL®
Therapy & Balance Centers

Patient Consent & Financial Agreement

Authorization for Treatment

Physical therapy and all self-pay 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 and all self-pay service(s) offered if I so choose. I understand that physical therapy and all self-pay services 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

Patient Consent for Audio Recording

I acknowledge and understand that FYZICAL Sarasota Downtown will be using PredictionHealth's AI scribing software service (the "Software"), during our visits moving forward.
This software will record and process the audio of our conversation to auto-generate the Provider's documentation and administrative work to help ensure the highest quality of care possible.
By signing this Audio Recording Consent Form, I expressly certify that I understand that:

A. The provider will be using the software to capture conversations between myself and the Provider in order to auto-generate the Provider's documentation and administrative work.

B. The audio will be processed by the Software and will record my protected health information.

C. The audio recording will be used for clinical purposes only, including treatment, payment or health care operations in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). It will not be used for any other purposes, including, for example, sharing, selling or using the audio recording for advertising purposes not in accordance with HIPAA.

D. The audio recording will be stored securely as part of my medical record in accordance with the applicable security regulations of HIPAA.

I have read all of the information above, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. By signing below, I expressly consent to the use of the Software and to have the audio of my visits recorded to support my Provider's clinical work.

_____ _____/_____/_____

Patient or Legal Guardian's Signature Date

Revised 12/23/21 SH

FYZICAL Therapy & Balance Centers

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 Cellular)	**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) Female (Mujer) 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) Work Injury Auto Accident Surgery Other		**Injury Date or Surgery Date:** (Fecha de lesion o cirugia) / /
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 is receiving home health services currently? YES NO
(¿El paciente recibe actualmente servicios de salud en el hogar?)
Has the patient received home health services in the past 30 days? YES NO
¿Ha recibido el paciente servicios de salud en el hogar en los últimos 30 días?
Are you receiving physical therapy services elsewhere? (Even for a non-related diagnosis). YES NO
¿Recibe servicios de fisioterapia en otro lugar?

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** / /_

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? 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 avoidthe 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:_____/_____/_____

FYZICAL Therapy & Balance Centers

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: _____

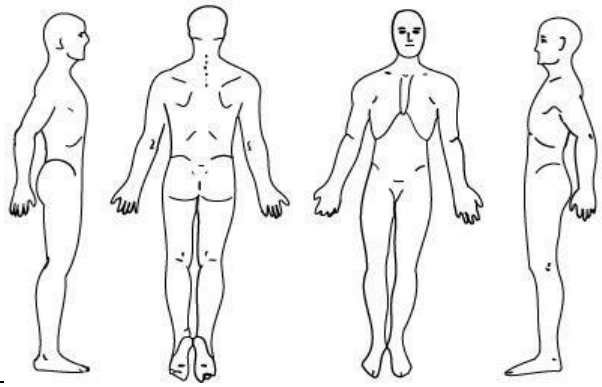
Please inform us of any environmental or living conditions that may have difficulties with: _____

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

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

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

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 compliant 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	
☐	☐	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 _____	

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**