1050 Key Parkway, Suite 202
Frederick, MD 21702
Phone: 240-813-3597 Fax: 240-594-0220

Patient Information

Last Name: ____________________ First Name: ____________________ Middle Initial: ________

Address: ____

City: ____________________ State: __________ Zip: ____________________

Date of Birth: ____________________ Sex: __________ Social Security # ____________________

Email: ____________________ Work #: ______________ Cell/Home #: ____________________

Marital Status: Single __________ Married __________ Divorced __________ Widowed ____________________

Emergency Contact: ____________________ Phone # ______________ Relationship ____________________

Referring/Primary Care Physician ____

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 (if other than above): ____

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: ______________________________

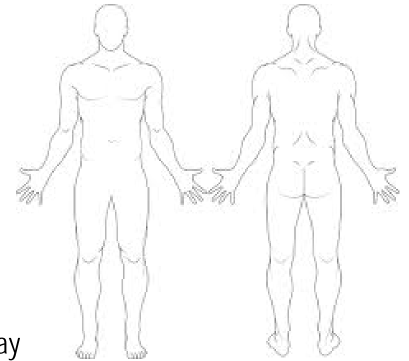
Please indicate your level of functioning prior to the onset of this condition: ______________________________

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):

Please Mark on the picture locations of pain



☐ 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		

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

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. NOTE: This is not a medical records release for physical therapy records; you must sign a separate Medical Release form to obtain records from our office. By signing this form, I understand that: -Protected health information may be disclosed or used for treatment, payment, or healthcare operations. Optimum Physical Therapy and Wellness, LLC reserves the right to change the privacy policy as allowed by law.

Optimum Physical Therapy and Wellness, LLC has the right to restrict the use of the information but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. Optimum Physical Therapy and Wellness, LLC may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES/ NO**

May we leave a message on your answering machine at home or on your cell phone? **YES/ NO**

May we discuss your medical condition with any member of your family**?** **YES /** **NO**. If YES, please

name the members allowed:

Name/Relationship:____

____

This consent was signed by: ____

(PRINT NAME PLEASE)____**Date:**__________

Witness: ____**Date:**__________