Fyzical Therapy & Balance Centers

4287 SE Federal Hwy. Stuart, FL 34997

Welcome Form

Date: _____ Birthdate: _____ SS#: _____

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

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

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Emergency Phone: _____ Body Weight: _____ Height: _____

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Partnered

Pain Scale: 1 2 3 4 5 6 7 8 9 10

It is **strongly** encouraged that you list your email so that our office may send you patient information like home exercise programs and videos, insurance updates, or monthly newsletters.

Email: _____

May we send you text messages or emails for appointment reminders? ☐ Email ☐ Text ☐ I prefer calls

Who is the responsible insurance party paying for this account: _____

Whom may we thank for referring you: _____

Injured as a result of a fall in the past year: ☐ **Yes** ☐ **No** **Two or more falls in the past year?** ☐ **Yes** ☐ **No**

Allergies	☐ Yes	No ☐	Emphysema/Bronchitis	☐ Yes	No ☐	Multiple Sclerosis	☐ Yes	No ☐
Anemia	☐ Yes	No ☐	Fibromyalgia	☐ Yes	No ☐	Muscular Disease	☐ Yes	No ☐
Anxiety	☐ Yes	No ☐	Fractures	☐ Yes	No ☐	Osteoporosis	☐ Yes	No ☐
Arthritis	☐ Yes	No ☐	Gallbladder Problems	☐ Yes	No ☐	Parkinson's	☐ Yes	No ☐
Asthma	☐ Yes	No ☐	Headaches	☐ Yes	No ☐	Rheumatoid Arthritis	☐ Yes	No ☐
Autoimmune Disease	☐ Yes	No ☐	Hearing Impairments	☐ Yes	No ☐	Seizures	☐ Yes	No ☐
Cancer	☐ Yes	No ☐	Hepatitis	☐ Yes	No ☐	Smoking	☐ Yes	No ☐
Cardiac Conditions	☐ Yes	No ☐	High Cholesterol	☐ Yes	No ☐	Speech Problems	☐ Yes	No ☐
Cardiac Pacemaker	☐ Yes	No ☐	High/Low Blood Pressure	☐ Yes	No ☐	Strokes	☐ Yes	No ☐
Chemical Dependency	☐ Yes	No ☐	HIV/AIDS	☐ Yes	No ☐	Thyroid Disease	☐ Yes	No ☐
Currently Pregnant	☐ Yes	No ☐	Incontinence	☐ Yes	No ☐	Tuberculosis	☐ Yes	No ☐
Depression	☐ Yes	No ☐	Kidney Problems	☐ Yes	No ☐	Vision Problems	☐ Yes	No ☐
Diabetes	☐ Yes	No ☐	Metal Implants	☐ Yes	No ☐	Other	☐ Yes	No ☐
Dizzy Spells	☐ Yes	No ☐	MRSA	☐ Yes	No ☐			

MEDICAL HISTORY

Notes: _____

Medications Currently Taking (Dosage and Reason Taking): _____

_____

_____

Surgical History (Body Part, Surgery Type, When): _____

_____

_____

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services. I also request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made to either me or on my behalf to Gina's Physical Therapy, Inc. for any services furnished to me by this provider.

Signature of Beneficiary, Guardian, or Personal Representative: _____

Date: _____ Relationship to Patient: _____

Patient Acknowledgement of The Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that information can and will be used to: -Conduct plan and direct my treatment any follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly - obtain information from third party payers - Conduct normal healthcare operations such as quality assessments and physical certifications.

By signing this document I acknowledge that you have provided me with a copy of your Notice of Privacy Practices - a more complete description of the uses and disclosures of my health information.
I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to get my current copy of the Notice of Privacy Practices. I understand that I may restrict in writing how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my required restrictions, but if you do agree then you are bound to such restrictions.

_____
Initials

Cancellation/NO SHOW Policy
I understand that there is a cancellation policy requiring me to give 24 hours notice to cancel appointment without penalty. I will be waived ONE grace visit of cancellation fees. After ONE grace visit of cancellation less than 24 hours I will be charged $30 for missing my agreed appointment. I understand this policy is in effect so I may get MY DESIRED OUTCOME.

_____
Initials

Home Health Requirement of NOTICE and STOPPING Outpatient

I understand that Medicare will not pay for Home Health Therapy and Fyzical Outpatient Therapy concurrently. If my doctor orders Home Health of any form (nursing, CNA,physical therapy, occupational therapy, speech therapy) I must inform Fyzical and place my outpatient plan of care on hold until I am FORMALLY DISCHARGED from Home Health. Failure to inform and place my therapy at FYZICAL on Hold will result in a fee equal to Medicare's denial due to concurrent treatment of home health and outpatient therapy.

_____
Initials

I agree to an ABN (Advanced Beneficiary Notice) with a fee of $10 for top of the line products, creams, patches, equipment not covered by my insurance in standard customary care. I may elect not to participate in this program and its subsequent benefits that are entitled with this paid fee.

Opt OUT _____ Opt IN _____
Initial One only

Patient Name_____ DOB_____

Patient Signature_____ Date _____