FYZICAL
Therapy & Balance Centers

Please Fill-Out Entire Form Completely and Legibly

PERSONAL INFO:

Sex: ☐ Male ☐ Female

_____ _____ _____
Last Name First Name MI

_____ _____ _____ Marital Status:
Date of Birth Age Social Security # ☐ Single ☐ Married ☐ Divorced ☐ Widowed

_____ _____ _____ _____
Address City State ZIP

_____ _____ _____
Home Phone # Cell Phone # Email:

_____ _____ _____
Emergency Contact: Phone #: Relationship:

_____ _____
Spouse: Phone #:

_____ _____ _____
Patient's Occupation: Employer Name: Work Phone #:

Work Status: ☐ Currently Employed ☐ Retired ☐ Disabled (___Total or ___ Temporary) Student: (___PT/ ___FT)

Preferred Contact for appointment reminder: ☐ Home ☐ Cell (☐ text ☐ voice) ☐ email: _____

REFERRAL INFO:

_____
Primary Care Physician/Nurse/Chiropractor:

_____ _____ _____ _____
City: State: Zip: Phone #

Are you currently under the care of a Home Health Agency? : ☐ No ☐ Yes : Agency Name: _____

How did you hear about us: ☐ Friend or Family (Who): _____ ☐ Brochure ☐ Internet
☐ Insurance/Directory ☐ Advertisement ☐ Other: _____

PAYMENT INFO: I am paying TODAY by…

PRIMARY INSURANCE: _____ Policy #: _____ Grp: # _____

Policy Holder's Name: _____ Relation to Patient: _____ DOB: _____

My Coinsurance/co-pay is $ _____ My Deductible is $ _____

SECONDARY: _____ Policy #: _____

If Patient is a Minor :
Responsible party for bill: _____ Relationship: _____

Date of Birth: _____

If **Auto/Workers Comp** : _____ _____
Adjustor name: Adjuster Ph #

☐ **WORKERS COMP**: Date of accident/Injury: _____

☐ **CASH, CHECK, CREDIT**

☐ I have an **ATTORNEY** and I will complete the "Attorney Lien" form. A deposit of $500 is required and will be applied towards the PT services.

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Consent for Treatment:

I hereby consent to receive care for services by Fyzical™. I consent to medical treatment as is deemed medically necessary as prescribed by my referring and/or primary care practitioner 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 other healthcare providers, and _____. I also authorize my record to be reviewed by any federal, state or local healthcare agency surveyors and /or quality assessment/utilization review staff for the purpose of ensuring quality of services provided. I also acknowledge that I have been provided with a copy of the *Notice of Privacy Policies.*

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, CT Scans, and MRI reports, along with Physician Documentation.

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Fyzical™. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment benefits.

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 dates of services are rendered. I am responsible for any incurred cost on overdue balances including, but not limited to, late fees, interest fees, legal fees and collection agency fees.

Policy Agreement:

I have read and agree to all the policies

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

Patient/Responsible Party Signature: _____ Date: _____

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Important Company Policies

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important policies. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

Initial All Boxes

☐ **Late Policy "10-minutes"**

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**

If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$25 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$25 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**

If you fail to show for an appointment without notice all future appointments will be removed and a ***$25 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**

Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked toterminate your session early and attend to your child.

☐ **Financial Hardship**

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**

"It is unlawful to routinely avoid paying your co-pay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Exceptional cases do apply.

We look forward to building a relationship with you that will last a lifetime!

Patient/Responsible Party Signature: _____ Date: _____