FYZICAL®
Therapy & Balance Centers

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 **$40 fee** that is due. The fee Is not billable to Insurances. The fee will be **due on or before the next appointment.** To avoid the 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 will fully commit to my plan of care so that I can reach my goals!

Patient _____ **Date** _____

Welcome to our office

We look forward to providing you with world class service. At FYZICAL we strive to provide comprehensive care of the whole person and total body wellbeing. Our highly trained staff will work on your behalf to elevate your current health status and help you LOVE YOUR LIFE!

Authorization for Treatment

Physical therapy 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 Pilates 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 consent to the rendering of physical therapy care by FYZICAL I also understand that I have the right to refuse any physical therapy service(s) offered if I so choose. I understand that physical therapy 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.

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. There may be exceptions, please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of small children.

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 participating insurance companies as a courtesy. I understand that all co-payments, coinsurance, 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 full responsibility to know and understand my health plan. I understand that FYZICAL is not responsible for any inaccurate information they receive from my insurance co. I understand that it is my responsibility to obtain necessary referrals from my doctor prior to coming to FYZICAL, if required by my insurance. Should the account be referred to an agency or attorney for collections, I agree to pay attorney's fees and collection expense. **I also agree to pay $35 for any returned checks**.

Credit Card/Debit Card Payments by signing this form you authorize FYZICAL and its affiliates to keep your credit card on file for future payments. **You have the option to decline this convenience and physically produce your card on any visit. If you decline this option, please initial here _____.**

Cancellation / No-Show Policy

Missed appointments represent a cost to FYZICAL, to you, and to other patients who could have been seen in the time slot set aside for you. Cancellations are requested 24 hours prior to the appointment time. We reserve the right to charge for missed or late-canceled appointments. Excessive cancellation/no-show of appointments may result in discharge from the practice. If you need to cancel or reschedule an appointment, please feel free to call us during our business hours. **By signing below you agree to pay $40 for all physical therapy appointments that are not canceled 24 hours prior to your scheduled treatment session**

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 Practices. You may request a written copy of the Notice at any time. You may also ask any questions about the Notice at any time.

I HAVE FULLY READ AND UNDERTSAND ALL THE ABOVE CONTENTS AND AGREE TO ACCEPT ITS TERMS BY SIGNING BELOW

_____ _____

Patient or Legal Guardian's Signature **Date**

Date:_____/_____/_____

Name: _____
(LAST) (FIRST) (MIDDLE)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: ( )_____-_____Work Phone: ( )_____-_____Cell: ( )_____-_____

SSN: ----------_____ Date of Birth: _____/_____/_____ Prounouns: _____

Marital Status: Single Married Divorced Widowed

Employer:_____ Occupation: _____

Employer's Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By:_____Area of Injury: _____

Type of Injury: ☐ Work Related ☐ Sports Injury ☐ Auto Accident ☐ Other: _____

Your email address: _____

SPOUSE AND/OR GUARDIAN INFORMATION

Name: _____ D.O.B._____/_____/_____ SSN ----------_____

Relationship:_____Employer:_____Occupation:_____

Emergency Contact:_____Relationship:_____Phone #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance Name: _____

Address:_____Phone#: _____

Name of Insured:_____ID#_____Group# _____

SECONDARY INSURANCE
Insurance Name: _____

Address:_____Phone#: _____

Name of Insured:_____ID#_____Group# _____

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. I authorize payment of medical benefits to FYZICAL

Patient Signature:_____**Date:** _____

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: _____

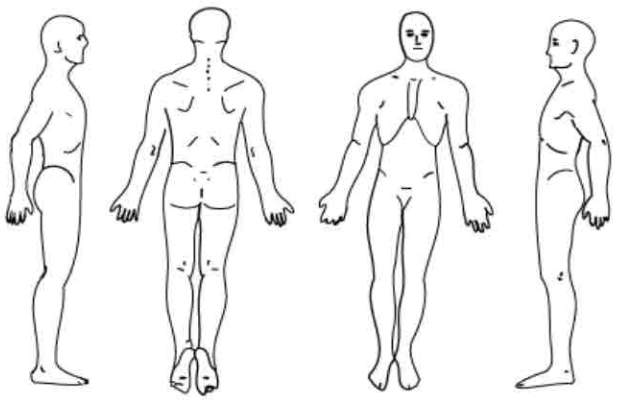
Please inform us of any environmental or living conditions that may have difficulties with: _____

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

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

- ☐ Vertigo
- ☐ 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

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	
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Cancer - Location: _____Date: _____
☐	☐	Tumor
☐	☐	Systemic Lupus/
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Drug or Alcohol Dependence
☐	☐	Hearing Loss
☐	☐	Pace Maker
☐	☐	Other _____

Present: Weight _____ Height _____ft _____in.

Have you fallen in the last year? ☐ NO ☐ YES - If yes, how many? _____

If you fell, did you have an injury? ☐ NO ☐ YES Type: _____

Are you diabetic? ☐ NO ☐ YES

Do you use tobacco products? ☐ NO ☐ YES If yes, packs/day? _____

Pain 0 (no symptoms) to 10 (unbearable symptoms):

Current _____ Best _____ Worst _____

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

_____

_____