FYZICAL®
Therapy & Balance Centers

Patient Information

Patient Name _____

Address:_____

City:_____ Zip:_____

Date of Birth:_____ Social Security #_____

Home Phone #:_____ Cell #:_____

Email Address _____

How did you hear about us?_____

Male _____ Female _____ Marital Status: Single____Married____Divorced____Widowed ____

Referring Doctor(s) _____

Diagnosis: _____

Insurance Information

Primary Insurance _____

Policy #_____ Group #:_____

Billing Address _____

Secondary Insurance _____

Policy #_____ Group #:_____

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 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 Signature:_____ Date:_____

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No-Show/Cancellation Appointment Policy

We strive to give you the attention you require. Please understand that scheduled appointment times are an important factor and we need proper notice of cancellations or reschedules to fill our appointment times. It is required that we have a 24 hour notice of a cancellation or reschedule. We do know that there are exceptions when circumstances arise that are beyond your control and you may need to cancel. Please notify us at your initial evaluation if there are any medical reasons that would hinder you from providing a 24 hour notice. The required notice is 24 hours, if a problem arises & you cannot make your appointment, please notify us so we do not consider you as a no-show.

We reserve the right to charge a **$75 fee** for a no-show appointment or an unexcused cancellation without proper 24 hour notice. The third no-show or unexcused cancellation will result in discharge due to non-compliance. This fee is your responsibility and is not a billable charge to your insurance.

Patient Signature _____ Date _____

Office Staff Signature _____ Date _____

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Authorization and Release

The undersigned hereby authorizes Fyzical Therapy and Balance Centers to photograph and/or videotape them during the course of a clinical treatment.

The undersigned acknowledges that these photographs and videotapes are for the express purpose of marketing, public relations or commercial representation of this company to the public. These pictures and videotapes are the property of **Fyzical Therapy and Balance Centers** and are not to be used for any other purpose without the express consent of _____ (client).

No other use of these pictures or videotapes is allowed or contemplated without the express permission of the undersigned.

Patient Signature _____ Date _____

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Patient Name: _____

DRUG NAME	FREQUENCY	DOSAGE

Coronavirus Disease Questionnaire

Name: _____Date: _____

Please Check the **Yes** or **No** boxes; do not check both boxes. Feel free to explain what a yes or no answer means in the Comment Section below the question.

1. Have you traveled outside of the United States or Oklahoma in past 30 days? Yes No
   If yes, please list the countries you have visited below.
   Comment:_____

2. Have you been in close contact with an individual who has traveled outside of the US in the past 30 days? Yes No
   If yes, please list the countries he/she has visited below.
   Comment:_____

3. Have you been in close contact, in the past 14 days, with an individual who has known to be infected with coronavirus (COVID-19)? Yes No

   If yes, have they been diagnosed and/or seen the doctor? Yes No
   Comment: _____

4. Have you had any these symptoms? Yes No
   - ☐ Fever over 100.4°
   - ☐ Persistent cough
   - ☐ Shortness of breath

   If yes, how long have you had these symptoms? _____
   If yes, have you been diagnosed and/or seen the doctor? Yes No
   Comment:_____

If you answered yes to any of the questions above, we will work with you to make accommodations for therapy to the best of our ability.
Please contact _____ at _____if you have questions. Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus 2019.

I am declining to complete this questionnaire. _____
Signature

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Patient Name: _____
Date: _____

Here at FYZICAL, we focus on all of you, not just an issue.

Our bodies are finely tuned instruments and subtle changes to one area often have unforeseen effects on another. We seek to understand any misalignment, pressures or stressors in life. It is all connected!

1.	Have you fallen in the past year?	☐ Yes	☐ No
2.	Do you have a fear of falling?	☐ Yes	☐ No
3.	Do you experience dizziness or feel unsteady or imbalanced?	☐ Yes	☐ No
4.	Do you lose your balance when stepping up/down curbs or stairs?	☐ Yes	☐ No
5.	Do you have a difficult time walking in the dark?	☐ Yes	☐ No
6.	Would you like to access your balance?	☐ Yes	☐ No
7.	Do you ever have to rush to the bathroom?	☐ Yes	☐ No
8.	Do you have difficulty hearing?	☐ Yes	☐ No
9.	Do you have osteoporosis, osteoarthritis and/or joint pain?	☐ Yes	☐ No
10.	Do you take bone and/or joint supplements?	☐ Yes	☐ No
11.	Do you experience muscle aches, pains and/or cramping?	☐ Yes	☐ No
12.	Do you use cold, heat or compression therapy at home?	☐ Yes	☐ No
13.	Are you interested in learning how compression and ice could help?	☐ Yes	☐ No
14.	Are you interested in learning how heat or ice therapy could help?	☐ Yes	☐ No
15.	Do you have foot and/or ankle pain or discomfort?	☐ Yes	☐ No
16.	Do you currently wear shoe inserts?	☐ Yes	☐ No
17.	Are you interested in learning about how a shoe insert could help?	☐ Yes	☐ No
18.	Do you have pain and/or physical challenges other than what you are being seen for today?	☐ Yes	☐ No
19.	Would you like to learn more information about your whole-body health and wellness?	☐ Yes	☐ No
20.	Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	☐ Yes	☐ No