Patient Information

Last Name: ____________________________First Name: ________________________Middle Initial:__________

Address:____

City:__________________________________State: ___________ Zip:___________________________

Date of Birth:____________________Sex:__________Social Security #__________________________

Home Phone #:__________________Work Phone #:_______________Cell #:_______________________

Marital Status: Single__________Married__________Divorced__________Widowed______________________

Emergency Contact: ________________________Phone #______________Relationship__________________

Primary Care Physician / Family Doctor(s)____

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:___________________