EXPRESS PATIENT REGISTRATION

Personal Information

____________________ ____________________ _______ ☐ Male ☐ Female

Last Name First Name DOB Gender

____

Street Address City State Zip

____

Home Phone # Cell Phone # E-Mail Address (important)

____

Occupation Employer Work phone #

Current Work Status: □ Full Duty □ Restricted □ Unable □ Retired □ Disabled □Student □ N/A or Unemployed

My condition is related to: □ Work □ Auto Accident □ Sports □ Surgery □ Injury □ Other □ Unknown

____

Emergency Contact Person Emergency contact #

______________________________ □ Same or ____________________

Name of your referring physician Name of Primary Care Physician

How did you hear about us? □ Physician □ Family/Friend □ Saw Location □ Internet □ other_____________

Payment Options

□ I have insurance (please complete Assignment of Benefits Form authorizing us to deal with them for you)

□ I have a work related injury under worker's compensation □ I was in an automobile accident going thru auto insurance

□ I will be "self-pay" and would like to take advantage of our "self-pay" discount (please ask to hear details on this)

***Accepted forms of payment include: Visa, Mastercard, Discover Card, Amex, Care Credit, Check, Cash

***I understand that I am responsible for my payment or portion of payment due according to my health insurance benefits at the time of service. I authorize FYZICAL Therapy & Balance Centers to evaluate me and initiate appropriate treatments.

______________________________ ____________________

Signature Date

** (If Minor) I authorize FYZICAL Therapy & Balance Centers to treat my child/dependent: ______________________________

FYZICAL Therapy & Balance Centers Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. **Please describe your problem:** ____

____

____

2. **What caused your pain/or problem?** ☐ **Unknown or** ______________________________

____

3. **Approximately when did it start?** ____/____/20_____

4. **What are your goals in therapy or your recovery?**

____

____

Please List Allergies:

Type: ______________________________

Type: ______________________________

Type: ______________________________

Surgeries:

Type:: ______________________________ Date____________

Type: ______________________________ Date____________

Type: ______________________________ Date: ___________

Type: ______________________________ Date:___________

Type: ______________________________ Date:___________

Type: ______________________________ Date:___________

Physical Therapist Initials____________

FYZICAL Therapy & Balance Centers- Medication Form

(**Mandatory documentation of current medications needed**)

A Current Medication List/ Photocopy Can Be used in Place of this Page

Over The Counter Medications	Name of Medication	Dose	Frequency
	______________________________	_________	________
	______________________________	_________	________
	______________________________	_________	________
	______________________________	_________	________

Prescribed Medications	Name of Medication	Dose	Frequency
	______________________________	_________	_________
	______________________________	_________	_________
	______________________________	_________	_________
	______________________________	_________	_________
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FYZICAL Therapy & Balance Centers

Statement of Privacy Notice

Effective February 2, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (770) 704-8244. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (770) 704-8244. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide FYZICAL Therapy & Balance Centers with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____

Patient's Name (print)

____

Patient's Signature Date

____

Authorized Facility Signature Date

Policy for Cancellations and No-Shows

Your attendance is very important to your recovery and your commitment to your rehabilitation is very important. Usually, your referring doctor and/or your therapist will prescribe a set frequency for treatment. Your therapist will review your PLAN OF CARE that specifies this and you can discuss your ability to attend PT at that time. This will allow you to start your therapy on the same page as your therapist and devise a plan that best suits your needs.

- We **require 24 hours notice** in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind. Remember, you should strive to attend your full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days or if scheduling conflicts prevent a re-schedule)

- There is a **$40 charge for a cancellation without proper notice**. This charge will not be covered by insurance but you will be responsible for this charge personally. We will review any emergencies/ illness & discuss on a case by case basis to determine any justification to waive this fee.

- **Worker's Compensation and Personal Injury Patients**: documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- If you have an **increase in pain** or soreness, please keep your scheduled appointment time. Your therapist may review potential causes and make modifications as necessary. In addition, they may be helpful in reducing your pain. It is not a valid excuse to cancel due to being sore or having some increase in pain. Plan on discussing your situation with your therapist during your scheduled appointment time.

- If your **pain has decreased and you are feeling better**, discuss this with your therapist. You may be able to advance your rehabilitation, or transition to more independent rehab. Either way, this is great news and time to review things with your therapist.

- Missing your scheduled visit **hurts 3 people**: 1) you may hinder your rehabilitation potential 2) you may take an appointment that another patient could have benefited from. 3) Your therapist now has a gap in his/ her schedule

______________________________ ______________________________

Patient Signature Date FYZICAL Staff signature Date

Please cooperate with us in this regard. We're looking forward to working with you and helping you regain the quality of life you want.

FORM NOT REQUIRED FOR WORKERS COMP

Assignment of Benefits to SOAR PHYSICAL THERAPY DBA: FYZICAL

Patient Name:____ D.O.B_______________

Primary Insurance_________________________________ Secondary Insurance__________________________________

ID #______________________________________ Policy #____________________________________

Insured Name (if other than patient): ____ and DOB____________________

I hereby instruct and direct my insurance company (outlined above) to pay by check or electronic funds to be made out and mailed to:

FYZICAL Therapy & Balance Centers
6884 Hickory Flat Hwy
Woodstock, GA 30188
(770)704-8244

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand and agree to the statements below:

- A photocopy of this AOB shall be considered as effective and valid as the original.
- 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 of benefits.
- I authorize FYZICAL Therapy & Balance Centers to submit claims to my insurance.
- I authorize FYZICAL Therapy & Balance Centers to deposit checks made in my name (HSA/HRA) for services rendered to me by FYZICAL Therapy & Balance Centers.
- I authorize FYZICAL Therapy & Balance Centers to initiate an appeal for any denials, and/or file a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance. In the event my account is sent to collections, I agree a 35% (minimum of $35) fee will be added.

Dated this ______ day of ____________________, 20_____.

___________________________________ ________________________________

Signature of Policyholder (or claimant) Witness

Home Health

Have you received **ANY** Home Health Care in the last **60 days** including any healthcare provider physically coming to your home to perform any service? **Yes/ No**

If yes, please provide last date of service: __________ Telephone Number: ____________ Name of Agency: ______________________________