FYZICAL®

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: ________________

FYZICAL®

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: ______________________________

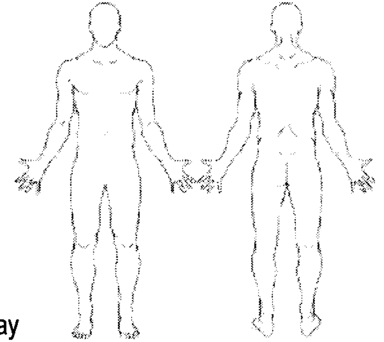
Please describe the nature of your symptoms (check **all** that apply):

☐ Vertigo
☐ Lightheadedness
☐ Imbalance
☐ Feeling "off"
☐ Ear Pressure/Pain
☐ Motion intolerant
☐ Migraine/Headaches
☐ Head Injury/Concussion

☐ 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 (No symptoms) to 10 (Unbearable symptoms) _____

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 assist your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure Angina
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Cancer – Location: Date:
☐	☐	Tumor
☐	☐	Systemic Lupus
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Incontinence
☐	☐	Other______________
☐	☐	Tobacco Use – packs/day:
☐	☐	Drug or Alcohol Dependence

Present: Weight _____ Height _____ft _____in.
Have you fallen in the last year? ☐ NO ☐ YES - If yes, how many? _____

Medication: (Name/Dosage/Frequency/Route Administered)

____

____

____

____

****If you need additional room for medications please bring a separate document on your next visit**

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

____

____

____

Do you have a Pace Maker: ☐NO ☐YES

FYZICAL®
Therapy & Balance Centers

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:
*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
*Obtaining payment from third party payers (e.g. my insurance company);
*The day to day healthcare operations of this practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, pay the health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent , in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: ____

Signature:____Date:____________________

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your wellbeing and the gain of your physical abilities is something that everyone in the clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our service; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies, it is expected that you keep all of your appointments. If you need to re-schedule an appointment, we required 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice, or no-show to a scheduled appointment, we reserve the right to charge you a $25 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Wayne Goffin, MSPT
President of Fyzical Therapy & Balance Centers

I have read and understand this policy: ________________________ Date: __________

FYZICAL Therapy & Balance Centers

CLIENT NEEDS SURVEY

NAME

EMAIL CASE#

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