



Patient Consent & Financial Agreement

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 other fitness 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 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. I agree to reimburse FYZICAL for any and all funds that the insurance may send to me directly. I additionally agree to provide the related Explanation of Benefits to FYZICAL, if I'd like any adjustments to be considered.

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.

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 insurance companies as a courtesy. I understand that all co-payments, co-insurance, and 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 responsibility to know and understand my health plan. I understand that FYZICAL is not responsible for any inaccurate information they receive from my insurance. I understand that it is my responsibility to obtain necessary referrals from my doctor prior to coming to FYZICAL. Should my account be referred to an agency or attorney for collections, I may be responsible for any and all attorney and collection fees charged to FYZICAL associated with collecting the debt. I agree to pay an insufficient funds fee for any returned checks.

Credit Card/Debit Card Payments by signing this form I authorize FYZICAL and its affiliates to keep my credit card on file for future payments. I will be required to sign each receipt approving the charge. You have the option to decline this convenience and physically produce your card at every visit. If you would like to decline this option, please initial here

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 Practice and do not want a paper copy at this time. You may request a copy of the Notice and/or ask any questions about the Notice at any time.

My signature below is acknowledging the above consent and agreeing to the terms in its entirety.

Patient or Legal Guardian's Signature

_____/_____/_____
Date



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 appreciate 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 penalty that may be assessed. 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 fully commit to my plan of care so that I can reach my goals!

Patient Signature: _____

Date: _____/_____/_____

Client Health Questionnaire

Patient 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: _____

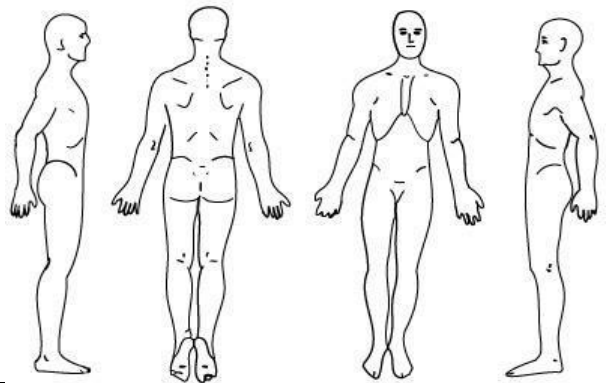
Please inform us of any environmental or living conditions that may have difficulties with: _____

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

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

- | | | |
|---|---|---|
| ☐ Vertigo | ☐ Sharp Pain | ☐ Constant (76 – 100%) |
| ☐ Lightheadedness | ☐ Dull (Pain) Ache | ☐ Frequent (51 – 75%) |
| ☐ Imbalance | ☐ Throbbing | ☐ Occasional (26 – 50%) |
| ☐ Feeling “off” | ☐ Numbness | ☐ Intermittent (25% - or less) |
| ☐ Ear Pressure/Pain | ☐ Shooting | |
| ☐ Motion intolerant | ☐ Burning | |
| ☐ Migraine/Headaches | ☐ Tingling | |
| ☐ Head Injury/Concussion | | |
| ☐ Tinnitus (ear ringing) | | |
| ☐ Sudden change in hearing | | |

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

Pelvic Health Questionnaire ☐ N/A

Please describe your current complaint or limitation: _____

Please tell us how long ago your condition started: _____

List tests or other interventions for this condition that you have had: _____

Did you have surgery? ☐ Yes ☐ No Procedure: _____

of Pregnancies: _____ Vaginal Births: _____ C-Sections: _____

Date of last Pelvic Exam: _____ Date of last Menstruation: _____

Your symptoms are worse in the ☐ Morning ☐ Afternoon ☐ Night ☐ increased During the Day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____



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	CONDITION
☐	☐	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 falls? _____

If you fell, did you have an injury? ☐ No ☐ Yes

Type of Injury: _____

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): _____

Please fill in the following list of your medications (including supplements and over the counter medications)

Medication Name	Dosage	Frequency	Route

Patient/Legal Guardian's Signature
Date