FYZICAL Therapy & Balance Centers

A Southern Therapy Services, Inc. Company

Southern Therapy Services, Inc.

Patient Registration Form

By accurately filling out this form in its entirety and with legible handwriting we will have better success in billing a clean claim to your insurance company.

Patient Information

Last Name	First Name	Middle

Mailing Address	Apt/Condo#

City	State	Zip

Home Phone	Cell Phone	Email

Fyzical at Southern Therapy Services uses a HIPAA compliant advanced communication platform that allows the patient to communicate with our office via text or in app messaging platform to receive patient reminders, cancel and reschedule appointments, communicate with your provider and much more

Date of Birth (mm/dd/yyyy)	Gender	Social Security Number
/ /	○ Female ○ Male	

Marital Status	Employer's Name and Phone #	Occupation
Single Married Widowed Other		

Emergency Contact Person	Emergency Contact Phone #	Relationship to Patient

Related cause to why you are being seen in our office	Injury Date or Surgery Date
☐ Work Injury ☐ Auto Accident ☐ Surgery ☐ Other (Explain):	/ /

Referring Physician or Name of Primary Care Physician	Name of Practice Group and Phone #	Date of Last Visit with Physician
		/ /

Insurance Name #1	Policy/ID Number	Group Number

Insurance Name #2	Policy/ID Number	Group Number

Spouse and or Guardian Information

Last Name	First Name	Date of Birth
		/ /

Social Security Number	Relationship to Patient	Employer's Name

Is the patient is receiving home health services currently? YES NO

Has the patient received home health services in the past 30 days? YES NO

Are you receiving physical therapy services elsewhere? (Even for a non-related diagnosis). YES NO

By signing below the patient and/or guarantor is confirming all of the information provided above is accurate, current and valid.

Patient/Legal Guardian's Signature: **Date:** / /

FYZICAL Therapy & Balance Centers

A Southern Therapy Services, Inc. Company

INFORMED CONSENT FOR PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, AND/OR FITNESS & WELLNESS

Dear Valued Patient:

Rehabilitation or wellness programs involve the use of different types of evaluation, screenings, and treatment. At Southern Therapy Services, Inc./FYZICAL, we use a variety of procedures, techniques, and modalities to help improve function, wellness, or disability. As with any form of medical care, there are benefits and potential risks. Each individual is unique and may respond differently to proven treatment. We cannot guarantee precisely your reaction/response to treatment nor can we guarantee that it will be successful. We strive to bring the most up-to-date and evidence based care to the people we serve. There is a risk that your treatment may cause pain or aggravate an existing condition. Precautions are taken in order to help prevent this.

You have the right to ask your therapist what type of treatment they plan for you and the potential risks and benefits of any treatment/procedure. You have the right to decline any portion of your treatment at any time. You should report any discomfort to your therapist/provider.

I have read this consent form and understand the benefits and potential risks to my therapy and/or wellness program. I agree to fully cooperate and proceed with my established plan of care.

Patient Name:_____

Print

Signature:_____Date:___/___/_____

FYZICAL® Therapy & Balance Centers

A Southern Therapy Services, Inc. Company

Patient Consent & Financial Agreement

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 at Southern Therapy Services and its affiliates. I authorize payment of medical benefits to FYZICAL at Southern Therapy Services and its affiliates.

Initial Here:_____

Personal Valuables/Dependents/Visitors

It is understood and agreed that FYZICAL at Southern Therapy Services 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.

Initial Here:_____

Financial Agreement

I, the undersigned agree, to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that FYZICAL at Southern Therapy Services and its affiliates bill insurance companies as a courtesy. I understand that all co-payments, coinsurance, 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 at Southern Therapy Services 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 at Southern Therapy Services. 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 at Southern Therapy Services associated with collecting the debt. **I agree to pay an insufficient funds fee for any returned checks.**

Initial Here:_____

Credit Card/Debit Card Payments by signing this form I authorize FYZICAL at Southern Therapy Services 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 let the Client Care Specialist know upon your first checkout.

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.

Initial Here:_____

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

_____ _____/_____/_____

Patient or Legal Guardian's Signature Date

FYZICAL Therapy & Balance Centers

A Southern Therapy Services, Inc. Company

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: _____

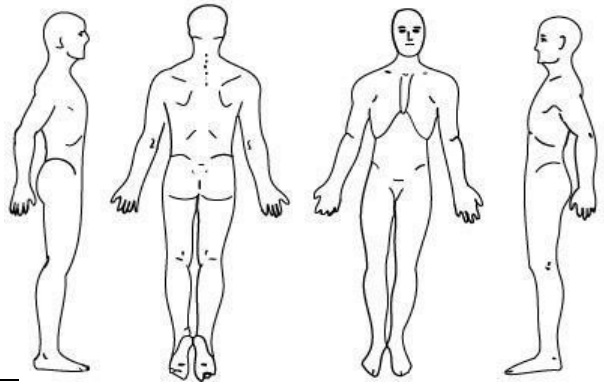
Please inform us of any environmental or living conditions that may have difficulties with: _____

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

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

- ☐ Vertigo
- ☐ Lightheadedness
- ☐ Imbalance
- ☐ Feeling "off"
- ☐ Ear Pressure/Pain
- ☐ Motion intolerant
- ☐ Migraine/Headaches
- ☐ Head Injury/Concussion
- ☐ Tinnitus (ear ringing)
- ☐ Sudden change in hearing
- ☐ 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 (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 compliant 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 Day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Revised 07/12/22 JCH

FYZICAL Therapy & Balance Centers

A Southern Therapy Services, Inc. Company

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. **Please answer to the best of your knowledge**

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**

Revised 07/12/22 JCH