FYZICAL
Dizziness & Fall Prevention Centers

CLIENT INFORMATION-Concussion Baseline Testing

Last Name:_____FirstName:_____MiddleInitial:_____

Address:_____Apt:_____

City:_____State:_____Zip:_____

Date of Birth:_____Sex:_____

Home Phone #:_____Work #:_____ Cell #:_____

Emergency Contact:_____Phone#:_____Relationship:_____

Primary Care Doctor:_____Are you currently receiving Physical Therapy: YES / NO

If yes, Company:_____

Are you interested in receiving Physical Therapy? _____

Consent for Treatment & Conditions of Services- "Adjunct Services"

Adjunct Services:
Services provided by FYZICAL Dizziness & Fall Prevention Center of North Andover that are (a) not a part of a physical therapy plan of care and/or (b) are not services and/or products reimbursable by insurance, and/or (c) are services that are reimbursable by insurance but that I elect to self-pay are Adjunct services. These include BodyQ examinations, Fall Risk Assessments, self-pay physical therapy treatments, continuation of care treatments, and fitness programs.

Consent:
I hereby consent to the procedures performed during the Fall Risk Assessment performed by FYZICAL Dizziness and Fall Prevention Center. I understand that I consent to medical treatment as is deemed necessary or advisable by the professional personnel of the clinic.

Consent to Release Medical Information:
I authorize FYZICAL to release any information acquired in connection with my adjunct services including, but not limited to, diagnosis, clinical records, to myself and my physician(s), and _____

Non-Insurance Charges:
Services delivered by FYZICAL to me that I elect to receive will not be submitted to my insurance company(s) for reimbursement. These are non-insurance charges, so no referrals, pre-certifications, prior authorizations, or the like will be requested by FYZICAL and, as such, will not affect my responsibility for payment as outlined under Financial Responsibility below.

Financial Responsibility:
It is agreed and understood that I, as the designated responsible party, am responsible for the total charges for services, and I further agree that all amounts are due upon request and payable to the FYZICAL clinic prior to the delivery of services. I agree to pay for any and all charges and expenses incurred or to be incurred. It is further agreed and understood that should this account be delinquent and it becomes necessary for the account to be referred to an attorney or a collection agency for collection or suits, I, as the designated responsible party or entity, shall pay all patient charges, reasonable attorney's fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law.

Cost of Baseline Concussion Testing: ~~FREE~~

Client/Guardian/Legal Representative Signature: _____

Printed Name: _____ Date:_____