NEW ENGLAND ENT
& Facial Plastic Surgery

FYZICAL
Dizziness & Fall Prevention Center

CLIENT INFORMATION

Last Name:_____ FirstName:_____ MiddleInitial:_____
Address:_____ Apt:_____
City:_____ State:_____ Zip:_____
Date of Birth:_____ Sex:_____
Home Phone #:_____ Cell #:_____
Emergency Contact:_____ Phone#:_____ Relationship:_____
Primary Doctor:_____ Referring Doctor:_____
Are you currently receiving Home Health Care: YES / NO
If yes, Company:_____
Have you had any physical, occupational, or speech therapy this year? YES / NO
How did you hear about FYZICAL? _____

IF CLIENT IS A MINOR / ALTERNATIVE PARTY RESPONSIBLE

Responsible party for bill if other than client:_____ Relationship:_____
Responsible party's address (If different than above):_____
Date of Birth: _____ ~~Social Security:~~_____

Consent for Treatment:
I hereby consent to the procedures performed during visits to FYZICAL Dizziness and Fall Prevention Center, owned and operated by New England ENT & Facial Plastic Surgery. 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 for services rendered. FYZICAL may appeal for unpaid or delayed claims; however, I understand and agree that this does not relieve me of my responsibility for all charges incurred.

Medicare Annual Cap and Home Health Episodes:
Medicare places an annual limit ($2110 for 2021) on the combined total amount of physical therapy and speech therapy that can be received. Previous therapy in this calendar year counts toward that total. An exception to this cap may be made if both my physical therapist and referring doctor agree that I can continue to benefit from skilled care. I understand that if Medicare indicates I am in a home health episode during the course of my treatment, Medicare will not cover the cost of outpatient physical therapy and the claims will be my responsibility.

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.

Condition Precedent, Referrals, Pre-Certifications/Pre-Authorizations:
It is the patient's responsibility to obtain any necessary referrals, precertification, and authorizations. I understand that failure to do so will leave me financially responsible for the charges and that obtaining these referrals/pre-certifications/authorizations does not relieve me of financial liability.

Cancellation No-show policy:
I understand that my appointment is a reservation of time with a skilled health professional. Insufficient notice of missing an appointment detracts from my ability to get fully well and effects other patients as well. Appointments without sufficient notice (Less than 48 hours) or a no-show will be charged a $80 fee. My insurance does not cover these fees and it will be my responsibility to pay. If I repeatedly neglect my appointments, the office may dismiss me as a patient.

I hereby certify that I understand these rights as set forth.
I acknowledge that I have been informed of FYZICAL's Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have the option to request full details regarding the privacy of my information.
I have received a copy of the patients rights and responsibilities handout.

Client/Guardian/Legal Representative Signature: _____
Printed Name: _____ 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: _____

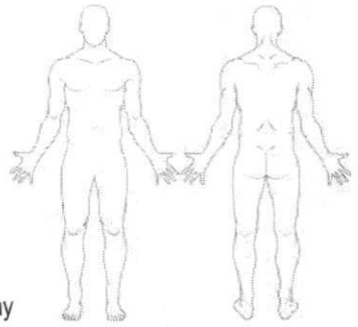
Please inform us of any environmental or living conditions that may have difficulties with: _____

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

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

☐ Vertigo	☐ 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		

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

Name: _____ Age/DOB: _____ Date of Injury:_____

Post Concussion Symptom Scale

No symptoms"0"-------Moderate "3"---------Severe"6"

Time after Concussion

SYMPTOMS	Days/Hrs _____	Days/Hrs _____	Days/Hrs _____
Headache	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Nausea	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Vomiting	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Balance problems	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Fatigue	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Trouble falling to sleep	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Excessive sleep	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Loss of sleep	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Light sensitivity	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Noise sensitivity	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Irritability	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Sadness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Nervousness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
More emotional	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Numbness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Feeling "slow"	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Feeling "foggy"	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Difficulty concentrating	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Difficulty remembering	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Visual problems	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
TOTAL SCORE	_____	_____	_____

Use of the Post-Concussion Symptom Scale: The athlete should fill out the form, on his or her own, in order to give a subjective value for each symptom. This form can be used with each encounter to track the athlete's progress towards the resolution of symptoms. Many athletes may have some of these reported symptoms at a baseline, such as concentration difficulties in the patient with attention-deficit disorder or sadness in an athlete with underlying depression, and must be taken into consideration when interpreting the score. Athletes do not have to be at a total score of zero to return to play if they already have had some symptoms prior to their concussion.