Clackamas ● Estacada ● Molalla
(503) 698-5500 Fax (503) 698-5501

FYZICAL®
Therapy & Balance Centers

PATIENT INFORMATION FORM

Patient Legal Name: _____ Preferred:_____ Date: _____

Birth Date: _____ SSN: _____ Age: _____

Gender: □ Male □ Female

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

***Appointment Reminder: ☐ Email Reminder ☐ None

Email Address: _____

Employer Information: _____ Occupation:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

Spouse Name:_____

Emergency Contact: _____ Phone: _____
Relation:_____

RESPONSIBLE PARTY INFORMATION
(Parent/Guardian must complete if patient under the age of 18 years old)

Parent/Guardian Name: _____ Relationship:_____
Date of Birth: _____ Phone: _____

HOW DID YOU LEARN ABOUT OUR CLINIC?

☐ My Physician ☐ I'm A Returning Patient ☐ Referred By Family Member ☐ Referred By A Friend
☐ Clinic Sign ☐ Internet/Clinic Website ☐ Other: _____
Whom Can We Thank For Referring You? _____

INSURANCE AND BILLING INFORMATION

Policy Holder Name: _____ DOB: _____ Relationship: _____
Insurance Carrier Name: _____ Phone Number: _____
Claim/Id Number: _____Group Number:_____ Injury Date: _____

Secondary Insurance

Policy Holder Name: _____ DOB: _____ Relationship: _____
Insurance Carrier Name: _____ Phone Number: _____
Claim/Id Number: _____ Group Number:_____ Injury Date: _____
Attorney Name: _____ Phone Number: _____

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PATIENT MEDICAL INFORMATION FORM

Patient Name: _____ Date of Birth:_____

Primary Care Physician: _____ Specialist:_____

Place of Employment: _____ Job Title:_____ How Long? _____

Job Activities Required: _____

Are you currently working? □ Yes □ No If yes, are you on: □ Light Duty □ Full Duty

When did your symptoms first begin? _____ Please indicate how your symptoms originally occurred:

□ Trauma □ Fall □ Lifting □ Auto □ Work injury □ Sports/Rec. □ Unknown □ Other:_____

CURRENT SYMPTOMS

Briefly describe your symptoms:

_____

_____

Please indicate descriptors that apply to your pain?

□ Aching □ Sharp □ Hot □ Dull □ Pinching □ Shooting □ Intermittent
□ Sore □ Throbbing □ Constant □ Stabbing □ Burning □ Pins and Needles

Status of symptoms since onset: □ Better □ Worse □ No Change

Are symptoms worse in the : □ AM □ PM □ Mid-Day

What activities increase your symptoms?_____

What activities decrease your symptoms? _____

Do you have difficulty sleeping through the night due to your symptoms? □ Yes □ No

PAST MEDICAL HISTORY

Have you had past history of similar symptoms: □ Yes □ No If yes,when?_____

Have you had any of the following test procedures: □ X-Ray □ MRI □ CT-Scan Other_____

Do you have a history of any of the following:

□ Cancer □ Diabetes □ Heart disease □ Osteopenia □ Osteoporosis □ Dizziness □ Stroke □ Fainting

□ High cholesterol □ High blood pressure □ Unexplained weight loss/ weight gain □ Bowel/bladder function changes

Are you /or could you be pregnant? : □ Yes □ No: □ N/A

Please list any previous surgeries and/or trauma even if it doesn't relate to your current symptoms:

_____

Medications: *Please list any medications. Include NAME of Medicine, FREQUENCY, and DOSAGE. Please attach a separate page if necessary.*

_____ _____

_____ _____

_____ _____

List any allergies (e.g., medicine,

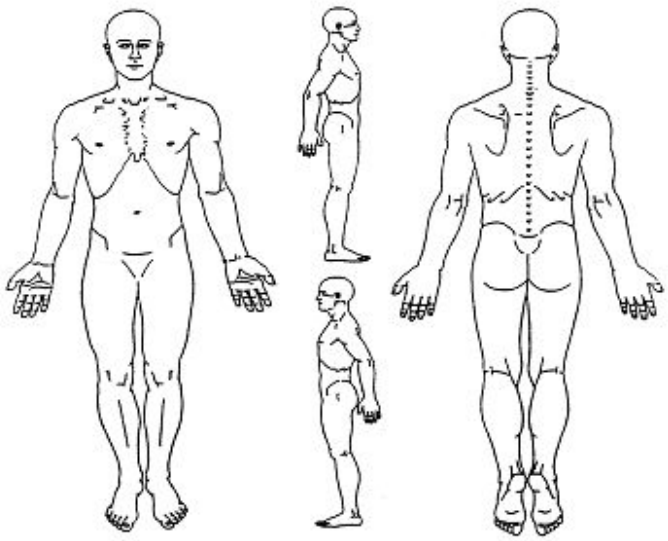
latex)?_____

Rate your pain level in the last 24 hours: best (B), worst (W), currently (C)

{ 0 1 2 3 4 5 6 7 8 9 10 }

No pain Moderate Intolerable

Indicate on the chart where you are experiencing pain



What goals do you hope to accomplish with Physical Therapy?

Please list 3 activities in your life you are unable to perform or are having the most difficulty performing, as a result of your injury or problem.

Scoring: Please score one number for each activity in the table below

{ 0 1 2 3 4 5 6 7 8 9 10 }

0= Unable to Able to Perform Activity *10=Able to Perform Activity*

	Goals/Activities	Score
1.		
2.		
3.		

Examples: Walking more than 15 minutes, sitting longer than 20 minutes, sleeping on my right side, specific work duties, housework or vacuuming, typing at my computer, carrying groceries, walking without assistive device, walking up/down stairs, fixing hair, bathing or dressing independently, playing sports, hiking, lifting children, caring for parent or spouse.

CONSENT TO TREAT

I authorize Fyzical Therapy & Balance Centers to provide physical therapy services to myself or my dependent. I understand that the information I have provided above is current and complete to the best of my knowledge.

_____

Patient Name (Print)

_____ _____

Signature of Patient or Representative **Today's Date**

FYZICAL®
Therapy & Balance Centers

FINANCIAL POLICY

Thank you for choosing Fyzical Therapy & Balance Centers for your physical therapy needs. We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding our financial/payment and attendance policy. Please read the below information and sign or initial where indicated.

We strongly encourage you to contact your insurance carrier for detailed Outpatient physical therapy

Insurance payments: I understand billing my insurance is a courtesy provided to me by Fyzical Therapy & Balance Center at no additional cost, and does not relieve my financial responsibilities. We request that all insurance companies pay our office directly. I authorize payments to be made on my behalf for physical therapy services furnished to me, to be made directly to Fyzical Therapy & Balance Center. I agree to inform Fyzical Therapy & Balance Centers of any changes to my personal information (such as address, phone, etc) and insurance (primary, secondary, other). I understand that failure to disclose this information in a timely manner could result in treatment being unpaid, and I will be responsible for payment in full. If my current policy prohibits direct payment, I hereby instruct and direct my insurance company to make the check to me and will then pay Fyzical Therapy & Balance Centers directly.

Non-covered services: I understand that some services may not be covered by all insurance carriers. Some insurance plans have certain restrictions/limitations (i.e.: pre-authorization, visit limitations and dollar limitations). I agree to be financially responsible for any and all charges not covered by my insurance. As a courtesy, Fyzical Therapy & Balance Centers will verify eligibility and benefits with your insurance company; however, this is not a guarantee of benefits or payment.

Payment: Payment is expected within 30 days after the first statement is sent and is considered past-due if a second statement is sent. Balances older than 60 days are subject to additional collection fees and interest charges of 1.5% per month. We accept cash, check, and most major credit cards.

Minor: If the patient is a minor, a parent or guardian must be present at the first visit to sign treatment authorization and payment agreement forms before the patient can be seen for treatment.

Release of Information: I give my permission to Fyzical Therapy & Balance Centers to release information, verbal and written, from my medical record to my physician, insurance company, case manager, attorney, or other allied health professionals as it relates to my treatment. I further authorize Fyzical Therapy & Balance Centers to obtain medical records from my physician or other medical professionals as it relates to my treatment.

Cancellation/Missed Appointment Policy

It is important that you keep your scheduled appointments. If you need to cancel or change an appointment, please notify us by 3:00 PM on the day prior to your appointment. Our office charges a $50.00 fee for each missed appointment without proper notice. These fees are not covered by insurance carriers and will be your responsibility to pay.

Patient or Representative Signature: _____

Notification and Acknowledgement of Notice of Privacy Practices (HIPAA)

Fyzical Therapy & Balance Centers is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. Fyzical Therapy & Balance Centers maintains the privacy of patient health information. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Patient or Representative Signature: _____

Consent For Treatment

I hereby authorize and give my consent to Fyzical Therapy & Balance Centers to provide me with physical therapy services that fall under the scope of practice in the State of Oregon.

I have read and understand, and agree to comply with the financial policies of Fyzical Therapy & Balance Centers and that I am financially responsible for my account.

Patient or Representative Signature _____ Date: _____

Employee Signature_____ Date: _____