



Patient Referral / Insurance Verification Form

Patient's Name: _____ M F Date: _____
Email Address: _____ Marital Status: M S D W
Home Address: _____
DOB: _____ Contact : (H) _____ (M) _____
Ref Phys: _____ Script: Y N Date: _____
Diagnosis: _____ ICD10: _____
Post-Surgical: Y N Date: _____ Stroke?: Y N Date: _____
Emergency Contact: _____ Phone#: _____ Relationship: _____

If patient is a minor:

Responsible party for bill of other than patient: _____ Relationship: _____
Responsible party's address (if other than above): _____
Date of Birth: _____ Social Security #: _____

Have you been to us before? Y N
How did you hear about us: DR / WI / CI / INS / Newsletter / Other: _____ Spanish / Creole
Have you had Physical and/or Occupational and/or Speech Therapy within the past 12 months? Y N
Mo/Yr: _____ Condition: _____ Approx # of visits used: _____
Have you had Physical Therapy in the past for this problem? Y N
Have you had any diagnostic tests related to this problem? (ie. MRI or X-Ray)
Please specify Where and When: _____

Have you received Home Health Care or Hospice Services within the past 12 months? Y N
Name of Home Health Agency: _____ Phone#: _____
Discharge Date: _____ Spoke with: _____

Are you being treated for injuries sustained from an Auto Accident, a Slip and Fall OR Work Related Injury? Y N
If Yes: WHEN? _____ HOW? _____ WHERE? _____
Employer's name, address, and phone #: _____

Are you currently working? Y N If Yes: How many hours a week? _____
What is your Occupation? _____

Are you taking any medications? Y N If yes: Please bring a list of all medications to your first visit.

I have read and reviewed the information herein and represent that the same is true, correct, and complete. I understand that FYZICAL and its health practitioners are relying upon the information in rendering treatment.

Signature: _____ Date: _____

Consent for Treatment

I hereby consent to receive care for therapy services by FYZICAL™ New Orleans. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information:

I authorize FYZICAL™ New Orleans to release any information acquired in connection with my therapy services, including, but not limited to diagnosis, clinical records, to myself, my insurances(s), physicians and _____.

Consent to Obtain Medical Information:

I authorize FYZICAL™ New Orleans to obtain and acquire any information that would be beneficial in connect 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™ New Orleans.

Guarantee of Payment:

I agree to pay any charges that my insurance does not pay. I am responsible to pay any uncovered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances, including, but not limited to late fees, interested fees, legal fees and collect agency fees.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature _____ Date: _____



Patient Initials: _____

NOTICE OF PATIENT INFORMATION PRACTICES-

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

FYZICAL™ New Orleans LEGAL DUTY

FYZICAL™ New Orleans is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

FYZICAL™ New Orleans uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, FYZICAL™ New Orleans may use your personal health information to contact you to provide appointment reminders or information about treatment alternative or other health related benefits that could be of interest to you. FYZICAL™ New Orleans may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law. In any other situation, FYZICAL™ New Orleans's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. FYZICAL™ New Orleans may change its policy at the time. When changes are made, a new Notice of Information Practices at any time.

CONCERN AND COMPLAINTS

If you are concerned that FYZICAL™ New Orleans may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPPA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information FYZICAL™ New Orleans health information practices, or if you have a complaint, please contact the following office:

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Signature _____ Date: _____

Please read and sign.

As a courtesy, FYZICAL™ New Orleans can call and check on your insurance benefits for physical therapy. As the insurance company states, the information given to us is not a guarantee of coverage or benefits. It is ultimately the patient's responsibility to know his/her insurance policy (for example: deductibles, coinsurance, co-payments, if referrals or pre-authorizations are required, what is covered and what is not covered by his/her plan).

To our Medicare patients: Medicare pays 80% of allowed charges after the annual deductible has been satisfied. The 20% coinsurance is billed to the patient unless there is a secondary/supplemental insurance. If there are benefits for physical therapy, the claim will be process according to the patient's insurance policy/contract.

If there is a patient responsibility after the insurance processes the claim or if there is no insurance, the patient is held responsible for the balance. FYZICAL™ New Orleans accepts cash, checks, Visa, MasterCard and Discover.

This is not a guarantee of coverage or benefits. You are responsible for payment.

Here is FYZICAL™ New Orleans, we strive to give you the attention you require. Please understand that scheduled appointment times are an important factor and your courtesy of cancellation is much appreciated. We do know that there are exceptions when circumstances arise that are beyond your control and need to cancel. **We reserve the right to charge a \$25.00 fee for a no-show appointment or a cancellation without 24 hour notice. This fee is your responsibility and is not a billable charge to your insurance.**

I have read and understand the above.

Patient's Signature

Date

CLIENT NEEDS SURVEY

- | | | | | |
|---|-----|-----------------------|----|-----------------------|
| 1. Have you had a fall in the past year? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 2. Do you have a fear of falling? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 3. Would you like your balance to be assessed? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 4. Do you experience dizziness or imbalance? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 5. Do you lose your balance when stepping up/down curbs or stairs/steps? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 6. Do you have a difficult time walking in the dark? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 7. Do you have difficulty hearing? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 8. Do you have osteoporosis, osteoarthritis and/or joint pain? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 9. Do you take bone and/or joint supplements? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 10. Do you experience muscle aches, pains and/or muscle cramping? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 11. Do you use cold, heat or compression therapy at home? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 12. Are you interested in learning how compression clothing with ice could help your condition? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 13. Are you interested in learning how home heat and/or cold therapy could help your condition? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 14. Do you have foot and/or ankle pain/discomfort? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 15. Do you currently wear shoe inserts? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 16. Are you interested in learning about how a shoe insert could help your condition? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 17. Do you have pain and/or physical challenges other than what you are being seen for today? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 18. Would you like to get more information about your wholebody health? | Yes | <input type="radio"/> | No | <input type="radio"/> |
| 19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition? | Yes | <input type="radio"/> | No | <input type="radio"/> |

Please rate your pain from 0 (no pain) to 10 (worst imaginable pain) at

Worst	0	1	2	3	4	5	6	7	8	9	10
Now	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

Date of injury onset: _____

What initially caused your pain:

PAST MEDICAL HISTORY

Do you have, or have you had, any of the following? (Please circle all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Balance |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Bowel / Bladder Issues (Incontinence) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Fever, Higher than 100 Degrees F |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Liver / Gallbladder Problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Low Exercise Level |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Open Wounds | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker or Defibrillator |
| <input type="checkbox"/> Perforated Ear Drums | <input type="checkbox"/> Radiation Treatment within last 3 mos. |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness of Breath/Difficulty Breathing |
| <input type="checkbox"/> Skin Rashes | <input type="checkbox"/> Stomach or Intestinal Issues |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tingling In Arms / Hands | <input type="checkbox"/> Tingling In Legs / Feet |
| <input type="checkbox"/> Typhoid/cholera/dysentery | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Other Health Issues (please explain) | |