FYZICAL THERAPY

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Social Security # _____

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

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____

Emergency Contact: _____ Phone # _____ Relationship _____

Primary Care Physician / Family Doctor(s) _____

Are you currently under the care of a Home Health Agency? ____No ____Yes, name of Co. _____

How did you hear about Fyzical™? _____

Insurance Information

Medicare # _____ Part B effective date _____

Insurance Policy # _____ Group #: _____

Policyholder's Name: _____ Relation to Patient: _____ DOB: _____

Insurance Address (if other than above): _____

If Patient is a minor

Responsible party for bill if other than patient: _____ Relationship: _____

Responsible party's address (if other than above): _____

Date of Birth: _____ Social Security # _____

Consent for Treatment:
I hereby consent to receive care for therapy services by Fyzical™. 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™~~.

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.

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

Patient/Responsible Party Signature _____ Date: _____

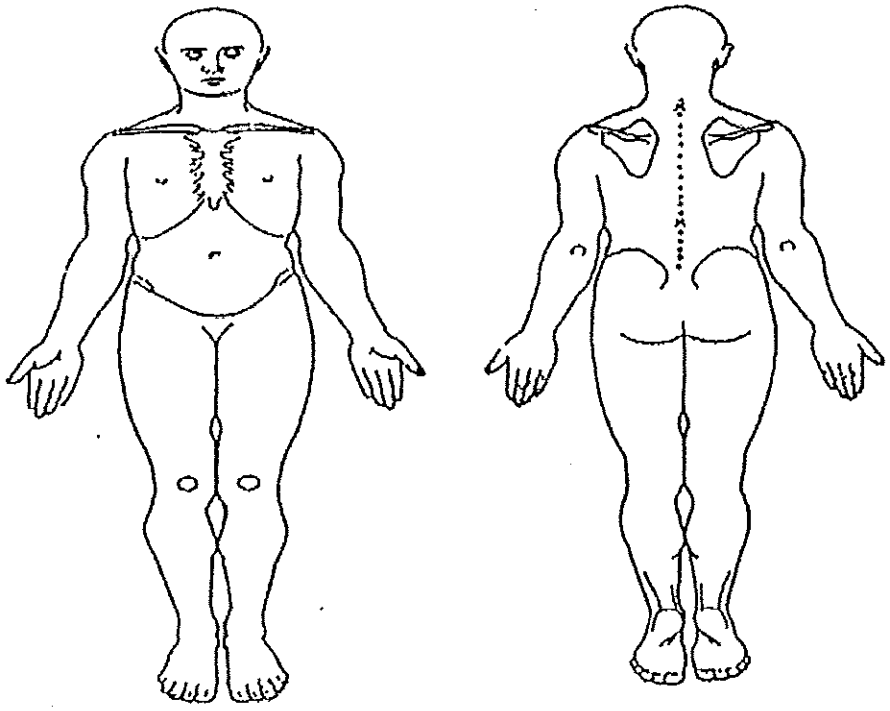
Fyzical

Medical Intake Form

NAME _____ DATE _____

PRESENT CONDITION: PAIN / TENSION

Please place an "X" in the area or areas where you are experiencing pain/symptoms.



Pleas circle the words that best describe your pain.

SEVERE	DULL	STABBING	MODERATE
BURNING	NUMBNESS / TINGLING	THROBBING	WEAKNESS
SHARP	RADIATING		

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?_____

_____

Since it has started, has the pain changed? Yes _____ No _____

Have your symptoms become **Worse** _____ **Better** _____ **The Same** _____

How often do you experience the pain? _____

What makes your symptoms worse?

Sitting _____ **Standing** _____ **Lifting** _____ **Bending** _____

How much does your pain/problem interfere with your **Daily Activities?**

None 20% 40% 60% 80% 100% of the day.

Have you had any diagnostic tests related to this problem? (I.e., MRI or X-Rays)

Please Specify Where and When_____

Have you had any Physical Therapy in the past 12 months for this or any other problem?
Yes _____ No _____

If Yes, Where?
_____When?_____

Have you had a related surgery? Yes _____ No _____

If yes, what was the date? _____

PAST MEDICAL HISTORY

Do you have, or have you had, any of the following?

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

_____

_____

_____

Are you taking any medication? Yes _____ No _____

If yes, please list
medications_____

Referring Physician

Physician's Name: _____Tel #_____

Address: _____

Address City ST ZC

WORK

Are you currently working? Yes _____ No _____

If yes, how many hours a week? _____

What is your occupation? _____

Please describe what you do at your job _____

_____

Patient's Signature _____ Date _____

FYZICAL®
Therapy & Balance Centers

Neville Flowers, M.S., PT
Michael Flowers, PT

219-10 South Conduit Ave
Springfield Gardens, NY 11413
Phone: (718) 525-8109
Fax: (718) 527-3028
flowers@fyzical.com

INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient,

Physical Therapy involves the use of many different types of physical evaluation and treatment. At Neville A. Flowers P.T. P.C., we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Neville A. Flowers P.T. P.C., and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

Patient Name	Patient Signature	Date

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2015 MEDICARE BENEFIT EXPLANATION

This letter is to inform you of your Medicare Benefit for the year 2015.

- EACH PATIENT IS ALLOWED $1920.00 PHYSICAL THERAPY CAP FOR THE **ENTIRE** 2015 YEAR.

(WE ASK THAT EACH PATIENT USE THERE P.T BENEFIT ONLY WHEN NECESSARY, TRY NOT TO USE ENTIRE BENEFIT AT ONCE IF IT IS **NOT MEDICALLY NECESSARY**

- Medicare only covers 80 % of physical therapy services leaving a 20% co insurance, you will be responsible for the coinsurance if you do not have a secondary insurance carrier.

- Each patient will be responsible for a **DEDUCTIBLE** at the beginning of each calendar year. For those with a secondary carrier, the carrier MAY pick up Medicare deductible and or Coinsurance. Please refer to your secondary carrier's policy to find out your Physical Therapy benefits

(PLEASE NOTE SOME SECONDARY INSURANCE CARRIES A DEDUCTIBLE AND OR COINSURANCE OF THIER OWN THAT YOU MAY BE RESPONSIBLE FOR)

2015 MEDICARE BENEFIT EXPLANATION

- Medicare does have an exceptions process for additional visits

(THIS PROCESS IS NOT A GURANTEE MEDICARE WILL PAY). To use this exception process a ABN form (Advance Beneficiary Notice which supplied by Medicare) will be presented to you for your signature each and every time you come into our office to be treated outside of the allowed number of visits. Payment for therapy service will be collected from you the patient on each visit. If and when Medicare pay for these services, your payments for services will be refunded.

This Notice is for you the patient's benefit, so you will be aware of your benefit under Medicare.

Patient Signature: _____ Date: _____

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MEDICARE PATIENTS

HOME HEALTH CARE ENROLLMENT

I _____ am NOT enrolled with a home health care agency.

Patient Signature: _____ Date: _____

Please note: As per Medicare policy guidelines patients who are enrolled with a home health agency for **ANY** medical services **CANNOT** receive physical therapy treatment until patient is discharged from the agency. Failure to advise this office of your enrollment will result in all claims becoming your responsibility.

I _____ am/was enrolled with a home health care agency as of _____ and was discharged on _____. I am aware that I must supply a discharge letter from the home health agency to continue treatment.

Please Note: as per Medicare policy guidelines patients who are enrolled with a home health agency for **ANY** medical services **CANNOT** receive physical therapy treatment until patient is discharged from the agency, Failure to advise this office of your enrollment will result in all claims becoming your responsibility.

Patient Signature: _____ Date: _____

Bwrdd Iechyd Lleol
Local Health Board
Powys

TINNETTI'S FALLS EFFICACY SCALE

ASSESSED BY.....

DATE OF ASSESSMENT.....

PLACE OF ASSESSMENT.....

On a scale of 1 to 10, 1 being extremely confident and 10 having no confidence at all, how confident are you at.....

Question	Circle best answer Most confident ⟷ Least confident
Taking a bath or shower?	1 2 3 4 5 6 7 8 9 10
Reaching into cupboards?	1 2 3 4 5 6 7 8 9 10
Preparing a meal (not requiring carrying heavy or hot objects?	1 2 3 4 5 6 7 8 9 10
Walking around the house?	1 2 3 4 5 6 7 8 9 10
Getting in and out of bed?	1 2 3 4 5 6 7 8 9 10
Answering the door or telephone?	1 2 3 4 5 6 7 8 9 10
Getting in and out of a chair?	1 2 3 4 5 6 7 8 9 10
Getting dressed or undressed?	1 2 3 4 5 6 7 8 9 10
Doing light housekeeping?	1 2 3 4 5 6 7 8 9 10
Doing simple shopping?	1 2 3 4 5 6 7 8 9 10

Score	

Can be repeated pre and post fall prevention.