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:_____

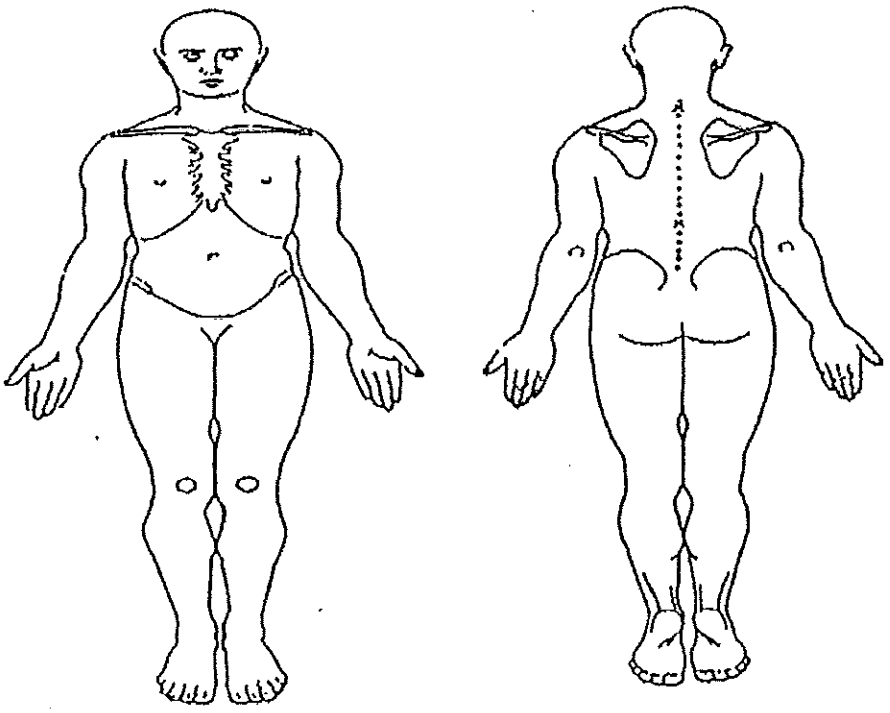
# Fyzical

## 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 |
|---|---|---|

## WORKER'S COMPENSATION

Employer/Co: _____

Address: _____

City_____ ST_____ ZC_____

Tel#: _____ ID# _____

Insurance Co _____

Contact _____

Address _____

City _____ ST_____ ZC_____

Tel#_____ Date of Accident_____

Type of Accident_____

Accident Claim #_____

Policy #_____

Attorney Name_____

Address_____

City_____ ST_____ ZC_____

Tel#_____

## NO FAULT

Employer/Co: _____

Address: _____

City_____ ST_____ ZC_____

Tel#: _____ ID# _____

Insurance Co _____

Contact _____

Address _____

City _____ ST_____ ZC_____

Tel#_____ Date of Accident_____

Type of Accident_____

Accident Claim #_____

Policy #_____

Attorney Name_____

Address_____

City_____ ST_____ ZC_____

Tel#_____

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flowers@fyzical.com

# STATEMENT OF LIEN

I, _____, hereby authorize and

Patient Name

Direct my attorney, _____, to pay directly to

Attorney Name

My Physical Therapist, Neville Flowers, PT.PC any and all of my outstanding bills for Physical Therapy treatments fro proceeds of any recovery in my case. I also understand and agree that, should there be no recovery in the case. I remain fully responsible for any outstanding monies owing to Neville Flowers, PT. PC.

**BILLS ARE NON-NEGOTIABLE**

Patient's signature_____ Date _____

I, _____, hereby recognize this lien

Attorney Name

And will pay any and all outstanding monies due and owing for Physical Therapy treatments rendered to the above-mentioned patient, immediately upon any recovery in this case.

Attorney's Signature_____ Date_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) (Signature of Provider)

_____ _____
(Date of signature)

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)