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: ________________

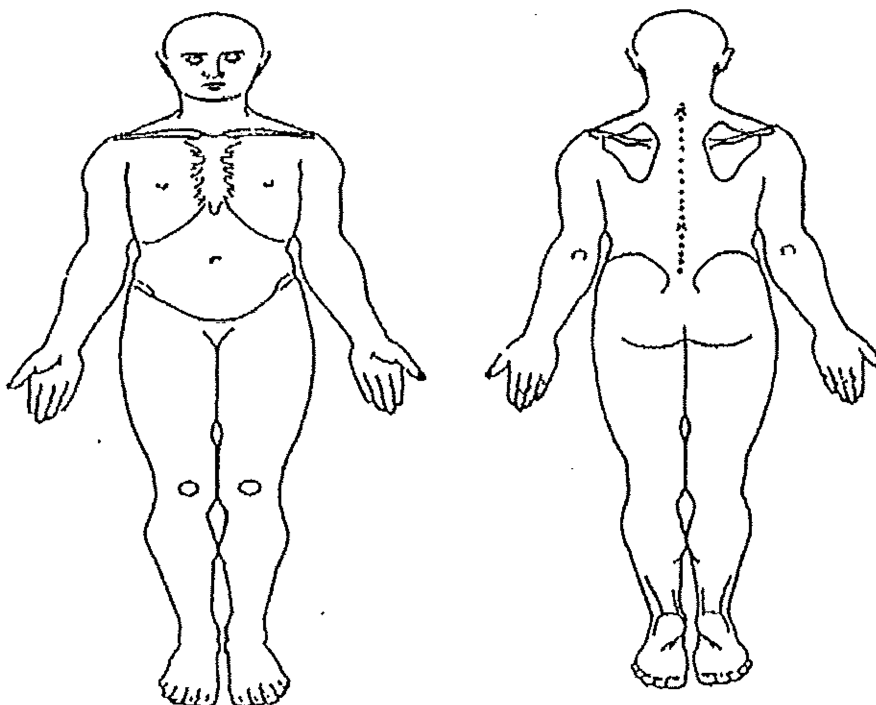
Fyzical

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

____

____

____

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 ____________

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____________________

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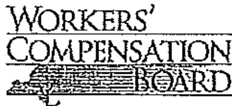
City__________ ST______ ZC______

Tel#____________________



CENTRALIZED MAILING, PO Box 5205, Binghamton, NY 13902-5205

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ☐WCB ☐DB ☐Discrimination and/or Date of Accident
IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).		
CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.		

INSTRUCTIONS:
Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, ______________________________,
Claimant's Name

represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

NEVILLE A. FLOWERS, PT.PC. ______________________________, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

219 - 10 SOUTH CONDUIT AVENUE, SPRINGFIELD GARDENS, NEW YORK 11413 ____.
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

______________________________ ______________________
Claimant's Signature (ink only -- use blue ballpoint pen if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.