**Welcome to our office**
We would like to welcome you as a patient. We realize that no one really wants to be here, but we hope your time here is informative and provides future health benefits. Your initial visit will consist of a thorough examination to determine the needs and best activities for your recovery. At some point during your treatment , you may go to our gym facility. Please wear or bring proper gym attire. Lockers and showers are available in the men's and women's restrooms at our Cheyenne location only. We encourage you to ask any questions regarding your care. Our staff is here to work with you as a team, to ensure you receive the best care. Our pledge is to provide clinical and customer service excellence with each visit. We want you to have a positive experience here at Fyzical SPORTS.

**Authorization for Treatment**
Physical therapy services offered at Fyzical SPORTS includes, but not limited to: evaluation techniques, soft tissue techniques, manual therapy techniques, heat, cold, electrical stimulation, electrical modalities, paraffin, stretching activities, strengthening exercises, cervical/lumbar traction, and the use of gym and/or Pilates equipment.

I have been informed that if any soft tissue technique, particularly Graston technique / active release / cross-fiber friction mobilization, are used, it may cause bruising and tenderness in the region that is/was treated. If the technique is too uncomfortable I will bring it to the attention of my physical therapist so that the procedure can be modified or ceased.

I consent to the rendering of physical therapy care by Fyzical SPORTS I also understand that I have the right to refuse any physical therapy service(s) offered if I so choose. I understand that physical therapy may involve some risk and I hereby release S.P.O.R.T.S. from liability now or in the future.

**Assignment of Insurance Benefits and Release of Information**
I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits, insurance payments be made to Fyzical SPORTS . I authorize payment of medical benefits to Fyzical SPORTS.

**Personal Valuables/Dependents/Visitors**
It is understood and agreed that Fyzical SPORTS is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, if children are present, please keep them off the exercise equipment in order to prevent injuries. There may be exceptions, please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of small children.

**Financial Agreement**
I, the undersigned agree, to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that Fyzical SPORTS bills participating insurance companies as a courtesy. I understand that all copayments, coinsurance, deductibles are due at the time of service. I understand that benefits quoted to me are only an estimate. I understand that it is my full responsibility to know and understand my health plan. I understand that Fyzical SPORTS is not responsible for any inaccurate information they receive from my insurance co. I understand that it is my responsibility to obtain necessary referrals from my doctor prior to coming to Fyzical SPORTS, if required by my insurance. Should the account be referred to an agency or attorney for collections, I agree to pay attorney's fees and collection expense. I agree to pay $25 for any returned checks.

**Cancellation / No-Show Policy**
Missed appointments represent a cost to Fyzical SPORTS, to you, and to other patients who could have been seen in the time slot set aside for you. Cancellations are requested 24 hours prior to the appointment time. We reserve the right to charge for missed or late-canceled appointments. Excessive cancellation/no-show of appointments may result in discharge from the practice. If you need to cancel or reschedule an appointment, please feel free to call us during our business hours. Cheyenne: 702.655.8535. I agree to pay $25 for all physical therapy appointments that are not canceled 24 hours prior to my scheduled treatment session.

**Notice of Privacy Practices**
Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As indicated in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you are stating that you have reviewed the Notice of Privacy Practices. You may request a written copy of the Notice at any time. You may also ask any questions about the Notice at any time.

**I HAVE FULLY READ AND UNDERTSAND ALL THE ABOVE CONTENTS AND AGREE TO ACCEPT ITS TERMS**

| Signature of Patient or Responsible Party | Print Name | Date |
|---|---|---|

Date: _____/_____/_____

Name: _____
(LAST) (FIRST) (MIDDLE)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: (  ) _____-_____ Work Phone: (  ) _____- _____ Cell: (  ) _____-_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Employer: _____ Occupation: _____

Employer's Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By: _____ Area of Injury: _____

Type of Injury: ☐ Work Related ☐ Sports Injury ☐ Auto Accident ☐ Other: _____

Your email address: _____

## SPOUSE AND/OR GUARDIAN INFORMATION

Name: _____ D.O.B._____/____/_____ SSN: _____-___-_____

Relationship: _____ Employer: _____ Occupation:_____

Emergency Contact: _____ Relationship: _____ Phone #: _____

## INSURANCE INFORMATION

**PRIMARY INSURANCE**
Insurance Name: _____

Address: _____Phone#: _____

Name of Insured: _____ ID# _____ Group# _____

**SECONDARY INSURANCE**
Insurance Name: _____

Address: _____Phone#: _____

Name of Insured: _____ ID# _____ Group# _____

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits, insurance payments be made to Fyzical SPORTS. I authorize payment of medical benefits to Fyzical SPORTS.

**Patient Signature:** _____ **Date:** _____

FYZICAL SPORTS THERAPY

# RECORDS RELEASE

To: _____

This request comes to your office on behalf of: _____
We are currently seeing him/her for physical therapy treatment and are in need of his/her records from your office.

I hereby authorize Fyzical SPORTS to inquire and request documents on my behalf regarding my care.

Patient Signature : _____ Date: _____

Please Print Name: _____

For office use only
Dated: _____ Coded: _____
Rqts: _____ Initials: _____

Date:_____
Date of Birth:_____

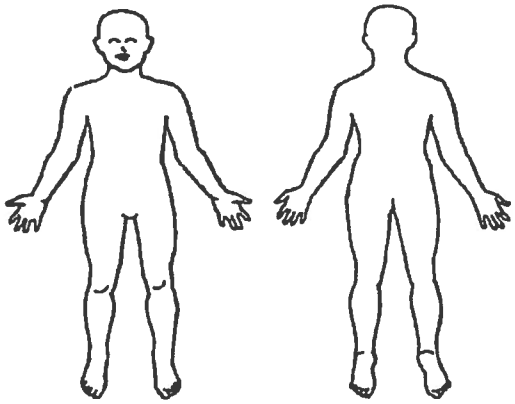
FYZICAL SPORTS THERAPY

Name:_____
Age:_____ Height:_____ Weight:_____ Occupation/School:_____
Referring Physician/Clinician:_____ Diagnosis:_____

## REASON FOR VISIT

When did the condition begin? ____/____/____
How did the injury occur? _____
Is this injury a result of a motor vehicle accident? YES NO Did this injury occur at work? YES NO
Did you have surgery for this condition? YES NO If yes, when? ____/____/____
Have you undergone any treatment for this condition? YES NO _____

**Body Chart**: Please mark the areas of your symptoms
/// Numbness
= Tingling
↓ Shooting/sharp pain
O Dull/achy pain



My symptoms are currently: (check all that apply)
☐ Come and go
☐ Are constant
☐ Change with activity
☐ Intermittent
☐ Getting better
☐ Getting worse
☐ Staying the same

What aggravates this condition? _____
What alleviates your symptoms? _____

On the pain scale below, please circle your current level of pain

0 1 2 3 4 5 6 7 8 9 10
(No pain) (Can be ignored) (Aggravating) (Interferes with most tasks) (Worst pain imaginable)

## MEDICAL HISTORY

Please list (or attach copy) any medications or supplements your are currently taking: _____

_____

Do you have or ever had any of the following diseases or conditions (please circle):

| | | | |
|---|---|---|---|
| Heart Attack | Diabetes | HIV/Aids | Osteoarthritis |
| Chest pain | Emphysema/COPD | Hepatitis | Rheumatoid arthritis |
| Shortness of Breath | Asthma | Shingles | Osteoporosis/penia |
| High Blood Pressure | Dementia/Parkinson's | Anemia | Fibromyalgia |
| Stroke/TIA | Multiple Sclerosis | Seizures | Neuropathy |
| Cancer:_____ | Kidney Problems | Dizziness | Alcohol/Drug Abuse |
| | Thyroid Problems | Nausea | Other:_____ |

Have you had any other orthopedic injuries/surgeries? YES NO _____
Have you had any falls? YES NO If so, when? _____
Do you smoke? YES NO How much? _____ For how long? _____
What type of exercise/recreation do you participate in? _____

# PHOTO & VIDEO RELEASE CONSENT

**Purpose of Consent:** By signing this form, you are consenting to allow ***SPORTS LLC, DBA FYZICAL SPORTS LLC*** and any associated staff members to use and distribute your photo and/or video.

**Right to Revoke:** You have the right to revoke this Release at any time by providing written notice of your revocation and submitting it to us. Please understand that revocation of this Release will not affect any action ***SPORTS LLC, DBA FYZICAL SPORTS LLC*** or staff took in reliance on this Release before receiving your revocation.

I hereby grant permission to allow ***SPORTS LLC, DBA FYZICAL SPORTS LLC*** to use the photograph and/or video of me. I hereby agree and acknowledge that my photo and/or video will be released to the public via public relation efforts of ***SPORTS LLC, DBA FYZICAL SPORTS LLC***. I further acknowledge and agree that my photo and/or video may be used by the media, including social media.

I waive the right of prior approval and hereby release ***SPORTS LLC, DBA FYZICAL SPORTS LLC*** from any and all claims for damages of any kind based on the use of my photo and/or video.

By signing below I agree and acknowledge that I have read and understood the above Release and agree to all terms described. I am of legal age and freely sign this Release.

**Signature of Person Photographed/Recorded** **Date**

**Full Name of Person Photographed/Recorded**

Please provide your contact information: Please note, we will not share your address, phone numbers, or other means of contact information with anyone outside of ***SPORTS LLC, DBA FYZICAL SPORTS LLC.***

**Mailing Address** **City, State** **Zip Code**

**Email Address** **Instagram and/or Twitter**

**Miracle Wave Consent**

Acoustic Wave Therapy

Miracle Wave is a state of the art acoustic wave therapy that breaks up scar tissue and adhesions to enhance healing.

Miracle Wave is not covered by insurance at this time as it does not have a billable CPT code.

Normally the cost of 1 treatment is $150 to $300 per session. At this time, as we continue to develop protocols and create research, proving that this treatment is beneficial to insurance companies, we will only charge $20 per session when being used in conjunction with physical therapy being billed to your insurance. If you are not using insurance and would like Miracle Wave, the cost will be $65 to $100.

In Summary, you will be charged for the following fee for Miracle Wave:

| | |
|---|---|
| **Miracle Wave with Physical Therapy billed to Insurance** | **$20** |
| **Miracle Wave only with no insurance being billed** | **$65-$100** |

Please check the following that applies to you so that we may determine if you are a candidate for Miracle Wave.

| | | | |
|---|---|---|---|
| **Coagulation disorders (haemophilia)** | **YES** | **or** | **NO** |
| **Use of anticoagulants, especially Marcumar** | **YES** | **or** | **NO** |
| **Thrombosis** | **YES** | **or** | **NO** |
| **Tumor diseases, carcinoma patient** | **YES** | **or** | **NO** |
| **Pregnant** | **YES** | **or** | **NO** |
| **Children in growth (growth plates)** | **YES** | **or** | **NO** |
| **Cortisone therapy up to 6 weeks prior to today** | **YES** | **or** | **NO** |

By signing below, you agree to the fees explained and certify that the information you have provided us is true. By providing false information, you release SPORTS, LLC of liability and take full responsibility for the consequences that may pertain to your health.

Date _____

Patient Name: _____ Patient Signature: _____

Reviewed By: _____ Date:_____

(Treating Physical Therapist Signature)