Welcome to our office

We look forward to providing you with world class service. At FYZICAL we strive to provide comprehensive care of the whole person and not just or immediate medical issue. Our highly trained staff will work on your behalf to elevate your current health status and help you LOVE YOUR LIFE!

Authorization for Treatment

Physical therapy services offered at FYZICAL Vegas 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 Vegas 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 FYZICAL Vegas 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 Vegas . I authorize payment of medical benefits to FYZICAL Vegas.

Personal Valuables/Dependents/Visitors

It is understood and agreed that FYZICAL Vegas 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 Vegas 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 Vegas 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 Vegas, 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. By signing this form you authorize FYZICAL Vegas to keep your credit card on file for future payments. You have the option to decline this convenience and physically produce your card on any visit.

Cancellation / No-Show Policy

Missed appointments represent a cost to FYZICAL Vegas, 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. 702-818-5000. 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 Vegas. I authorize payment of medical benefits to FYZICAL Vegas.

Patient Signature: _____ **Date:** _____

Thank you for choosing **FYZICAL**!

Welcome to FYZICAL Therapy and Balance Centers. We are very excited that you have chosen us to help you Love Your Life. Attached to this letter is the new patient paperwork that we will need you to complete. To make things go as smoothly as possible on your first visit and get you started on improving your quality of life, please follow the steps and tips listed below.

- Please fill out all of the papers attached. If you have questions about any of them, you can skip those parts until the date of your first visit.
- Please bring a photo ID card as well as your insurance card (if insurance will be billed) as well as a referral if your doctor gave you one.
- **If you are being treated for dizziness or balance**, please be sure to answer all of the questions on the Activities-Specific Balance Confidence scale as well as the Dizziness Handicap Inventory. If you do not do some of the activities listed, try to imagine how you would feel if you had to complete one of those activities and answer accordingly.
- **If you are being treated for reasons other than balance or dizziness,** you do not need to fill out the Activities-Specific Balance Confidence scale or the Dizziness Handicap Inventory. You also do not need to worry about the VNG Instructions (Page 2) of this packet.
- If you have any questions regarding this appointment, future appointments, or your insurance benefits, please give us a call ahead of time. Dial 702-880-1515 and use **option 2 if you are going to our Las Vegas** location or **option 3 if you are going to our Henderson** location.

Thank you again for choosing FYZICAL Therapy and Balance Centers!

See you soon!

LOVE YOUR LIFE

FYZICAL™
Therapy & Balance Centers

VNG Pre-Test Instructions

Your physician has recommended that you have a VNG (videonystagmography) evaluation. A VNG tests the organ in your inner ear that controls balance and dizziness to determine if some abnormality exists which may cause your dizziness. It helps us and your doctor find the cause of your balance problem and try to cure it.

This testing will take about one hour and will not cause you any pain. You may experience brief episodes of dizziness during some portions of the test. Although we know that dizziness can be scary or uncomfortable, be advised that our clinicians will strive to ensure your comfort during the testing procedures.

Please review all of the following instructions. **Failure to comply with these instructions will compromise test results and may result in the need to reschedule your test.** Please also fill out the list of medications on the following page and bring it with you to your appointment.

PLEASE READ ALL INSTRUCTIONS THOROUGHLY

48 hours prior to VNG testing:

- DO NOT consume alcohol
- DO NOT take any anti-dizziness medications (Meclizine, Antivert, Dramamine, or Valium)
- Refrain from taking any of the following medications
    - Narcotic pain relievers (i.e. Percocet, Vicodin)
    - Muscle relaxants
    - Sedatives or tranquilizers
    - Sleep aids (i.e. Ambien, Unisom, Tylenol PM)
    - Antihistamines (i.e. nasals sprays, allergy medications)
    - Cold medications or cough syrups
    - Antidepressants or anti-anxiety medications

It is STRONGLY advised that you contact your physician to ensure that these medications can be safely stopped. PLEASE CONTINUE TO TAKE ALL LIFE SUSTAINING MEDICATIONS such as medications for cardiac/heart disease, high blood pressure, and diabetes.

To help your testing go smoothly…

On the day of the testing:

- **PLEASE** complete the medications list found on the following page
- **DO NOT Eat** prior to testing. If your appointment is scheduled in the afternoon, you may eat a light breakfast. If you are diabetic, you may eat a light breakfast and/or light lunch.
- **DO NOT** wear any eye makeup to your appointment. This includes mascara, eyeliner, eye shadow, and false eyelashes as this affects the cameras ability to accurately test and measure eye movement
- **DO NOT** wear hard contacts. Soft contacts can be worn.
- Dress comfortably. You will be sitting and lying on the exam table during this testing.
- Because the test may cause dizziness you may not feel safe driving home. Please make arrangements for transportation to and from testing for safety.

If you have any questions or concerns about the testing procedure, please call (702) 880-1515 and speak with one of our audiologists, Dr. Michelle Hungerford or Dr. Lisa Gascay, or a member of our knowledgeable office staff.

FYZICAL Therapy & Balance Centers

CLIENT HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____

Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

Please tell us how long ago your condition started: _____

List tests or other interventions for this condition that you have had: _____

Please indicate the daily activities that you cannot perform: _____

Please indicate your level of functioning prior to the onset of this condition: _____

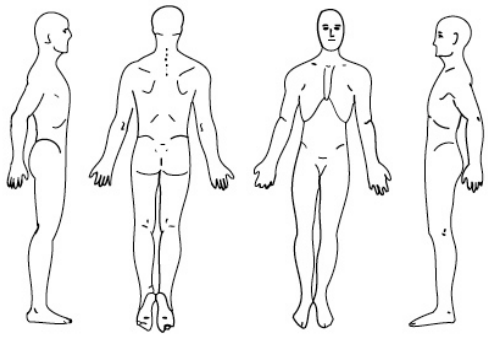
Please inform us of any environmental or living conditions that may have difficulties with: _____

Did you have surgery? ☐ No ☐ Yes Date _____ Procedure: _____

Please describe the nature of your symptoms (check **all** that apply):

- ☐ Vertigo
- ☐ Lightheadedness
- ☐ Imbalance
- ☐ Feeling "off"
- ☐ Ear Pressure/Pain
- ☐ Motion intolerant
- ☐ Migraine/Headaches
- ☐ Head Injury/Concussion
- ☐ Sharp Pain
- ☐ Dull (Pain) Ache
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Constant (76 – 100%)
- ☐ Frequent (51 – 75%)
- ☐ Occasional (26 – 50%)
- ☐ Intermittent (25% - or less)

Please Mark on the picture locations of pain



Level of symptoms at rest from 0 (No symptoms) to 10 (Unbearable symptoms) _____

Level of symptoms with activity from 0 (No symptoms) to 10 (Unbearable symptoms) _____

Since this condition began your symptoms have: ☐ decreased ☐ not changed ☐ increased

Your symptoms are worse in: ☐ morning ☐ afternoon ☐night ☐ increased during the day ☐ same all day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Occupation _____ Has your work status changed because of this condition ☐ YES ☐ NO

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Cancer - Location: _____Date: _____
☐	☐	Tumor
☐	☐	Systemic Lupus
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Other _____
☐	☐	Tobacco - packs/day _____
☐	☐	Drug or Alcohol Dependence

Present: Weight _____ Height _____ft _____in.

Have you fallen in the last year? ☐ NO ☐ YES - If yes, how many? _____

Medication: (Name/Dosage/Frequency/Route Administered)

_____

_____

_____

_____

_____

_____

_____

****If you need additional room for medications please bring a separate document on your next visit**

Hospitalization/Surgical Procedures (list if not described elsewhere):

_____

_____

Do you have a Pace Maker: ☐ NO ☐ YES

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Your Name: _____ DOB:_____Date:_____

The ACTIVITIES BALANCE CONFIDENCE (ABC) SCALE

For each of the following activities, please indicate you level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No confidence Moderately Confident Completely Confident

NOTE: If you are not currently performing the activity in question, try and IMAGINE how confident you would be if you HAD to perform the activity. Also, if you use an assistive device (walker, cane, etc.), you may rate it as if you were using that device.

*How confident are you that you will NOT lose your balance or become unsteady when you...

1. ...walk around the house? ____%
2. ...walk up or down the stairs? ____%
3. ...bend over and pick up a slipper from the front of a closet floor? ____%
4. ...reach for a small can off of a shelf at eye level? ____%
5. ...stand on your tip toes and reach for something above your head? ____%
6. ...stand on a chair and reach for something? ____%
7. ...sweep the floor? ____%
8. ...walk outside the house to a car parked in the driveway? ____%
9. ...get into or out of a car? ____%
10. ...walk across a parking lot to the mall? ____%
11. ...walk up or down a ramp? ____%
12. ...walk in a crowded mall where people rapidly walk past you? ____%
13. ...are bumped into by people as you walk through the mall? ____%
14. ...step onto or off of an escalator while you are holding onto a railing? ____%
15. ...step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
16. ...walk outside on icy sidewalks? ____%

FOR OFFICE USE ONLY: Scoring: _____ = _____ x100 = 0 _____%

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Patient Name_____Date:_____

Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. **Please do not skip any questions.**

Answer only with "Yes", "Sometimes", or "No"

1. Does looking up increase your problem?	Yes	Sometimes	No
2. Because of your problem, do you feel frustrated?	Yes	Sometimes	No
3. Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
4. Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
5. Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
6. Does your problem significantly restrict your participation in social activities such going out to dinner, going to movies, dancing, or to parties?	Yes	Sometimes	No
7. Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?	Yes	Sometimes	No
9. Because of your problem, are you afraid to leave home without having someone you?	Yes	Sometimes	No
10. Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
11. Do quick movements of your head increase your problem?	Yes	Sometimes	No
12. Because of your problem, do you avoid heights?	Yes	Sometimes	No
13. Does turning over in bed increase your problem?	Yes	Sometimes	No
14. Because of your problem, is it difficult for you to do strenuous housework or work?	Yes	Sometimes	No
15. Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
16. Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
17. Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
18. Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
19. Because of your problem, is it difficult for you to go for a walk around your in the dark?	Yes	Sometimes	No
20. Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
21. Because of your problem, do you feel handicapped?	Yes	Sometimes	No
22. Has your problem placed stress on your relationship with family or friends?	Yes	Sometimes	No
23. Because of your problem, are you depressed?	Yes	Sometimes	No
24. Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
25. Does bending over increase your problem?	Yes	Sometimes	No

FOR OFFICE USE ONLY *# of 'Yes'* _____*x4=*_____ *Total=* 0

*# of 'Sometimes'*_____*x2=*_____

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CLIENT HEALTH QUESTIONNAIRE

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

FYZICAL™
Therapy & Balance Centers
401 N Buffalo Dr. Suite 120 Las Vegas, NV 89145 Phone: 702-880-1515 Fax: 702-880-1511
9005 S Pecos Road Suite 2520 Henderson, NV 89074 Phone: 702-818-5000 Fax: 702-818-5001

Patient's Name _____ Date: _____

ADVANCE BENEFICIARY NOTICE (ABN)

You are receiving this notice because your insurance company, _____, may not cover the following tests performed at our clinic. The Computerized Posturography test is required and is standard for the assessment of all of our patients. This test will be performed on your first visit and again 30-90 days later for re-evaluation. The Hearing Test is performed based on your diagnosis and your referring doctor's referral.

CPT Code & Test		Cost
92548	Computerized Posturography	$110.00
92550 & 92557	Hearing Test	$40.00

I understand that the above test may not be covered by my insurance, and I am responsible for the above charge each time this test is performed. I am also aware that Fyzical Therapy and Balance Centers will attempt to bill my insurance carrier and if my insurance does cover this service I will be responsible for the amount my insurance company deems is my responsibility.

_____ _____

Date Signature of Patient or Person acting on Patient's Behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your Insurance, your health information on this form may be shared with your insurance.