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 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

CLIENT HEALTH QUESTIONNAIRE

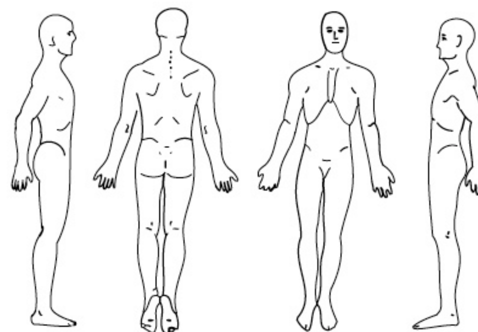
Name ______________________________ Age __________ Date ____________________

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

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