SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A PATIENT HAS THE RIGHT TO:

- Be treated with courtesy and respect, with appreciation of his/her dignity, and with protection of privacy.
- Receive a prompt and reasonable response to questions and requests.
- Know who is providing medical services and is responsible for his/her care.
- Know what patient support services are available, including if an interpreter is available if the patient does not speak English.
- Know what rules and regulations apply to his/her conduct.
- Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.
- Receive prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.
- Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such research.
- Express complaints regarding any violation of his/her rights.

A PATIENT IS RESPONSIBLE FOR:

- Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his/her health.
- Reporting unexpected changes in his/her condition to the health care provider.
- Reporting to the health care provider whether he/she understands a planned course of action and what is expected of him/her.
- Following the treatment plan recommended by the health care provider.
- Keeping appointments and, when unable to do so, notifying the health care provider or facility.
- His/her actions if treatment is refused or if the patient does not follow the health care provider’s instructions.
- Making sure financial responsibilities are carried out.
- Following health care facility conduct rules and regulations.

CLIENT HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____/_____/_____

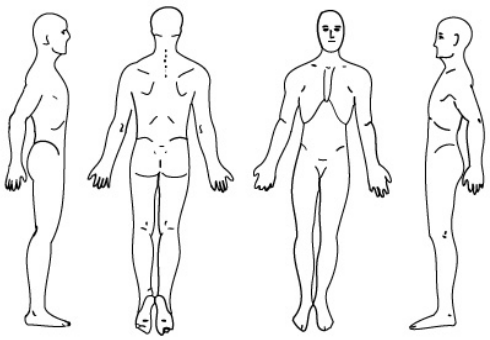
Please describe your Current Complaint or Limitation: _____
Please describe how your problem began: _____
Please tell us when your condition started: _____
List tests or other interventions for this condition that you have had: _____
Please indicate the daily activities that you cannot perform: _____
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 pain:

☐ Sharp Pain
☐ Dull (Pain) Ache
☐ Throbbing
☐ Numbness
☐ Shooting
☐ Burning
☐ Tingling

☐ Constant (76 – 100%)
☐ Frequent (51 – 75%)
☐ Occasional (26 – 50%)
☐ Intermittent (25% - or less)

MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS ➔➔➔➔



Indicate the intensity of your pain at **rest**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Indicate the intensity of your pain **with movement**: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
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 (I10.9)
☐	☐	Angina (I20.9)
☐	☐	Heart Attack (I21.9)
☐	☐	Stroke (I67.89)
☐	☐	Asthma (J45.909)
☐	☐	HIV/AIDS (B20)
☐	☐	Cancer (C80.1) Location: _____Date: _____
☐	☐	Benign Tumor (D36.9) Location: _____Date: _____
☐	☐	Systemic Lupus (M32.9)
☐	☐	Hepatitis (K73.9)
☐	☐	Epilepsy (G40)
☐	☐	Diabetes: Type I (E10.9) _____ Type II (E11.9) _____
☐	☐	Arthritis (M13.80) _____ Rheumatoid Arthritis (M06.9) _____
☐	☐	Pregnancy
☐	☐	Tobacco Use (Z72.0)
☐	☐	Vape Use (U07.0)
☐	☐	Drug Dependence (F19.10)
☐	☐	Alcohol Dependence (F10.10)
☐	☐	Other _____

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

_____
_____
_____

Do you have a Pacemaker: _____yes _____no

Medications:

_____
_____
_____

Present: Weight _____ Height _____ft _____in.

FYZICAL Therapy & Balance Centers

Client Information

Last Name _____ First Name _____ Middle Initial_____

Address_____

City _____State _____ Zip_____

Date of Birth_____ Sex_____ Social Security #_____

Home Phone #_____Cell #_____Work #_____

Email_____ Marital Status: (circle one) Single Married Divorced Widowed

Emergency Contact _____Phone #_____Relationship_____

Referring Physician _____ Primary Care Physician_____

Are you currently under the care of a Home Health Agency? ____No ____Yes, name of Co._____

Have you had physical, occupational, speech therapy, or chiropractic care this year? ☐ Yes ☐ No

How did you hear about FYZICAL?_____

If Client is a minor

Responsible party for bill if other than client_____ 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 or occupational 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), Legal Representation (if applicable, please include

Attorney's Name _____), 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.

I acknowledge that I have been informed of FYZICAL®'s Privacy Practices required by the **Health Insurance Portability and Accountability Act (HIPAA)** and have been presented with a brochure outlining these practices ☐ Yes ☐ No

I have received a copy of the **Summary of the Florida Client's Bill of Rights and Responsibilities** ☐ Yes ☐ No

Client/Responsible Party Signature_____ **Date**_____