Welcome to Excel Physical Therapy.

Please complete the following registration pages.

Last Name _____ First Name _____ MI _____ Gender: ☐ F ☐ M

Mailing Address _____ City _____ State _____ Zip _____

Primary Phone Number _____

PLEASE LET US KNOW HOW YOU PREFER TO RECEIVE APPOINTMENT REMINDERS BY EMAIL, TEXT OR PHONE CALL:
Select ONE:
Email ☐ Phone Call ☐ Text (I recognize that normal text messaging rates may apply)

Email Address - for internal purposes only, we do not sell your personal information _____

Social Security Number _____

Date of Birth _____

Driver's License License #:_____ State: _____
(if not providing a SSN, please provide your Driver's License info)

Employer's Name _____ Employer's Address _____ Work Phone _____

Release of Information - I authorize Excel Physical Therapy to release information on myself to the following person(s)/facility:

A=All info, M=Medical Only, B=Billing Only **Circle one**

Emergency Contact _____ Phone Number _____ Relationship to Patient _____ **A M B**

Other Contact _____ Phone Number _____ Relationship to Patient _____ **A M B**

Release of Records: Client Pickup, Fax, and/or Mail Only Facility: Fax and/or Mail Only

****Have you had PT this year at any other locations? _____ If yes, how many visits?_____

****Primary Care Provider Name and Location: _____

Who can we thank for telling you about us? _____

Guarantor The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section.

Grarantor's Last Name _____ Guarantor's First Name _____ Guarantor's Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Phone Number _____ Relationship to Patient _____ Social Security Number or Driver's License # _____ State _____

Employer Name and Address _____ Work Phone Number _____

Pre-Authorized Healthcare Payment & Card on File Agreement

I authorize **Excel Physical Therapy** to keep my signature on file through a secure PCI and HIPAA compliant payment processing system, to charge my credit card account (including flex plans or health savings plan debit cards) for any copays, coinsurance, deductible, prompt payment, supply item costs not covered by insurance or no-show/late cancellation fees incurred in relation to an appointment for the client named below. I understand that I will not be notified prior to the automatic charge on my card, however I understand I will receive a transaction email receipt if an email address is provided below. I understand that this form is valid until I cancel the authorization through written notice to Excel Physical Therapy.

Card Holder's Billing Information:

Billing Address: _____ City/State/Zip: _____

Card Holder's Name (printed) _____ DOB: _____

Full Account Number _____ Exp. Date: _____ CVV Code _____

Email (reciept): _____

Signature of Patient/Guarantor _____ **Date** _____ ☐ **Verbal Consent** **Front office initials** _____ **Date** _____

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CONSENT TO TREAT AND FINANCIAL POLICY (PT)

Patient Name (please print): _____

1. Permission is hereby granted to all Excel Physical Therapy healthcare providers involved in my case to administer examination, treatment, testing, and procedures deemed necessary in the course of my care.

2. I am financially responsible for all charges whether or not covered by private, workman's compensation or auto insurance. My signature below authorizes Excel Physical Therapy to bill my insurance and to directly receive payment of medical benefits for health care services rendered. I authorize release of any information, medical or other, necessary to process my claims. For my convenience, Excel will submit your insurance claims on your behalf. **Private insurance and Medicare do not pay for physical therapy supplies. You will be financially responsible for any supply items necessary for your treatment.** All patients will be responsible for payment if your insurance company rejects your claim, has exclusions for your type of treatment, will not pay our fee schedule in full or if the insurance denies due to timely filing. It is the patient or legal guardian's responsibility to provide our office with the most accurate and up-to-date insurance policy information so we may file your claims in a timely manner.

3. Payment of co-pays, co-insurance and/or deductible payments, when applicable, are due on the date of service. As medical providers, our relationship is with you, not your insurance company. Payments due are estimated and provided by your insurance company to our office and may result in a balance bill or refund after the explanation of benefits document is received by our office.

Please tell us how to bill your claim:

_____ **Private Insurance: Allegiance / BCBS / Cigna / EBMS / Health InfoNet PPO / Interwest PPO / Medicare / Mountain Health Co-op / MUST / Railroad Medicare / Tricare / Other**
We accept fee assignments from Allegiance, Blue Cross Blue Shield, Cigna, EBMS, Health InfoNet PPO, Interwest PPO, Medicare, Mountain Health Co-op, MUST, and Tricare. We bill most private insurance. A copy of all applicable insurance cards are required for us to bill your insurance. Please indicate primary, secondary or tertiary for any provided insurance carriers so the correct coordination of benefits is followed.
_____ **Workman's Compensation Injury/Accident:** We require the following before you can be treated by our practice: date of injury; claim number; workman's compensation insurance contact and adjustor information; employer contact and phone number.
_____ **Auto Accident**: Has your claim been disputed by the insurance company? ___ Yes ___ No If yes, then you must notify our front office staff before any treatment begins. Please provide us with your attorney's name and contact information prior to treatment, if applicable.
_____ **Prompt Pay (self-pay):** Please ask about our prompt pay appointment discount option prior to your appointment.

4. **No-Show/Cancellation Policy:**
Please provide our office with **24-hours notice** to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hours notice to change a scheduled appointment are responsible for a **$70.00** office visit charge and **$140.00** for 90-minute specialty appointments. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment. FO initials_____
We reserve your appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hours notice allows us to place another patient in your cancelled appointment period to receive needed treatment.
Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

5. Delinquent Accounts: We bill insurance as a courtesy. Any private insurance claims unpaid more than 45 days are your responsibility. All balances more than 60 days past due may be assessed a $2.00 billing fee per statement. Should my account become delinquent, I agree to pay all collection costs, attorney fees and court costs. Accounts will be assessed a $15.00 returned check fee for any returned check items.

6. Accounts with a balance of $10.00 or less will be written off as it is not cost effective to bill the responsible party a statement for such small amount. The same understanding goes for accounts with a credit of $10.00 or less.

7. Per **HIPAA** regulations, I acknowledge that this office has a posted Notice of Privacy Practice available in the patient reception area. A copy is available by request. We will not use or disclose your health information without your authorization except as described in this notice.

Thank you for choosing Excel Physical Therapy for your physical therapy services. Our practice is dedicated to providing you with the highest quality physical therapy care. A copy of this document is available by request.

_____ _____

Signature of Responsible Party (must be over 18 years old) Date

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Medical History and Current Condition

Do you or your immediate family member(s) have (circle yes or no)**:**

	Self	Family
Cancer?	yes/no	yes/no
Depression?	yes/no	yes/no
Diabetes?	yes/no	yes/no
Heart Problems?	yes/no	yes/no
High Blood Pressure	yes/no	yes/no
Angina/chest pain	yes/no	yes/no
Stroke	yes/no	yes/no
Osteoporosis	yes/no	yes/no
Osteoarthritis	yes/no	yes/no
Rheumatoid arthritis	yes/no	yes/no
Head/Neck/Spine Trauma	yes/no	yes/no
Fractures	yes/no	yes/no

Other_____

In the past 6 months have you had/do you currently have:

A major change in your health?	yes/no
Nausea/vomiting?	yes/no
Fever/chills/sweats/anxiety?	yes/no
Unexplained weight loss?	yes/no
Numbness or tingling?	yes/no
Changes in appetite?	yes/no
Difficulty swallowing?	yes/no
Changes in bowel/bladder function?	yes/no
Dizziness?	yes/no
Fainting?	yes/no
Double Vision?	yes/no
Difficulty Speaking?	yes/no
Shortness of breath?	yes/no
Upper respiratory infection?	yes/no
Urinary tract infection?	yes/no

Do you have a history of:

Allergies/asthma?	yes/no
Headaches?	yes/no
Bronchitis?	yes/no
Kidney disease?	yes/no
Rheumatic fever?	yes/no
Ulcers?	yes/no
Seizures?	yes/no

Are you currently:

Pregnant?	yes/no
Under severe stress?	yes/no

Are you currently having problems with:

Hearing?	yes/no
Speech?	yes/no
Vision?	yes/no
Communication?	yes/no

Please list past surgeries: **Date**

_____

_____

_____

_____

_____

Date of your last physical exam: _____

Have you had any medical images? (MRI, X-Ray, CT scan, bone density scan) Please indicate facility where completed:

Image Type / Facility Location **Date**

_____

_____

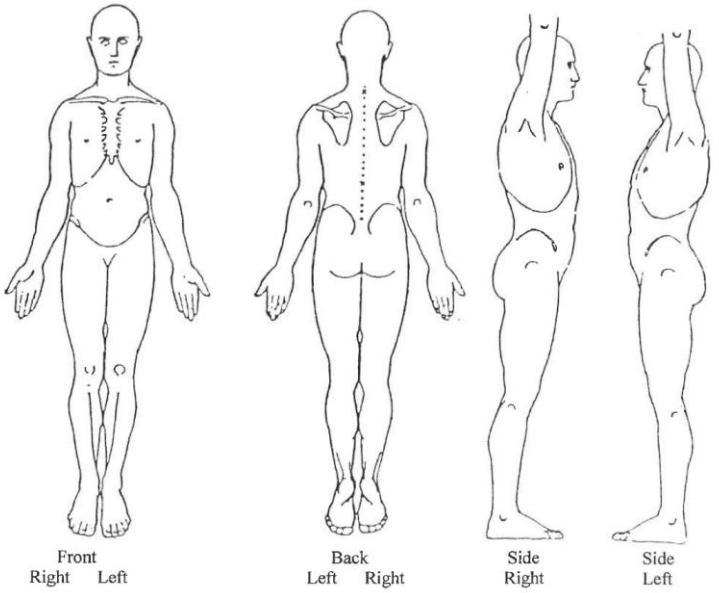
_____

_____

What are your symptoms? _____

_____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade or circle where appropriate).



When did your symptoms begin?

(Please indicate a specific date if possible) _____

Was the onset of the symptom gradual or sudden?

☐ Gradual ☐ Sudden

Since onset, are your symptoms getting:

☐ Better ☐ Worse ☐ Not changing

Nature of pain/symptoms (check all that apply)

☐ Sharp ☐ Aching ☐ Constant
☐ Dull ☐ Periodic ☐ Throbbing
☐ Occasional ☐ Other_____

Medication List

Please provide us with a list of any medications you are currently taking. Please include any past use of blood thinners and/or oral corticosteroids. We can take a copy of a list if you have one already.

Medication **Mg/dose** **#/day**

_____

_____

_____

_____

_____

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