Welcome to Excel Physical Therapy.
Please complete the following registration pages.

Last Name _____ First Name _____ Middle _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address - Only for therapist/patient communication/seminar & newsletter updates _____ Social Security Number _____ Gender: ☐ M ☐ F

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

Are you a student? (circle one) **Yes** **No** **Please complete Responsible Party section below if your parents are responsible for your bill.**

If yes, hometown address if different from above: _____

Employer's Name _____ Employer's Address _____

Spouse's Name _____ Spouse's Phone Number _____

In case of Emergency, Name and Phone Number of nearest relative: _____

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

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

***Referring Provider if different from above: _____**

*Who can we thank for telling you about us? _____

Responsible Party (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. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor'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 No. _____

Injury / Accident / MRI Information

Injury / Accident Date: _____

Is this a Worker's Compensation Claim? (circle one) Yes No **Claim ID Number** _____

Worker's Compensation Insurance Co. Name _____ Employer's Worker's Compensation Contact Name _____ Employer Contact Phone _____

Is today's visit a result of an auto / motorcycle injury? (circle one) **Yes** **No**

Attorney Name & Phone Number, if applicable_____

If you have had a recent MRI, indicate the date: _____ and circle location below:

☐Advanced Med. Imaging ☐Alpine Ortho ☐Bridger Ortho ☐Boz Deac. Imaging Other:_____

Insurance Information Please provide Front Office with all of your medical insurance cards & inform us if you have a secondary insurance provider.

Primary Insurance Co. Name _____ Subscriber Policy / ID Number _____ Group Number _____

Subscriber's Name if not patient _____ Policy Subscriber's Date of Birth _____ Subscriber's Relationship to Patient _____

Secondary Insurance Co. Name _____ Subscibers Name, if not patient _____ Secondary Policy / ID Number _____ Group Number _____

Bozeman 406.556.0562 www.excelptmt.com Manhattan 406.284.4262

CONSENT TO TREAT AND FINANCIAL POLICY

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, our office 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 / Montana Health Co-op / MUST / Railroad Medicare / New West / Tricare / Other**
We accept fee assignments from Allegiance, Blue Cross Blue Shield, Cigna, EBMS, Health InfoNet PPO, Interwest PPO, Medicare, Montana Health Co-op, MUST, New West and Tricare. We bill most private insurance. A copy of all applicable insurance cards are required for us to bill your insurance. Please make 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. Student Billing Policy: We cannot bill your parents by mail or phone as we are not authorized to do so. If your parents wish to be responsible for your office visit charges, they may call our office to leave a credit card number on file. Deductible and/or co-insurance charges will be billed after each office visit to the credit card. Otherwise, you, the patient, are directly responsible for any deductible or co-insurance payments at each office visit as dictated by your insurance company contract.

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

Revised 10/27/15

No-show/Cancellation and Appointment Reminder Policies

Patient Name: _____

Date: _____

NO SHOW / APPOINTMENT CANCELLATION POLICY

PLEASE READ CAREFULLY

1. 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 $50.00 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

2. 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.

3. 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.

_____ _____

Signature of Patient/Guarantor Date

Office Use Only:
Reviewed with Patient/Guarantor by:

_____

APPOINTMENT REMINDER PREFERENCE

PLEASE LET US KNOW HOW YOU PREFER TO RECEIVE APPOINTMENT REMINDERS BY EMAIL, TEXT OR PHONE:

CHOOSE ONE OF THE FOLLOWING:

☐ **EMAIL REMINDER:** Excel Physical Therapy may send email messages to confirm my appointments to (email address) _____

☐ **TEXT REMINDER:** Excel Physical Therapy may send cell phone text messages to confirm my appointments to (cell phone number) _____ ***I recognize that normal text messaging rates may apply.***

FOR TEXT MESSAGES, SELECT YOUR CARRIER:

- ◯ ALLTel
- ◯ AT&T
- ◯ Boost Mobile
- ◯ Cingular
- ◯ Cricket Wireless
- ◯ Metrocall
- ◯ MetroPCS
- ◯ Nextel
- ◯ Qwest
- ◯ Sprint PCS
- ◯ TMobile
- ◯ US Cellular
- ◯ Verizon
- ◯ Virgin Mobile
- ◯ Other: _____

☐ **PHONE REMINDER:** Please tell us which phone number we should call or leave a message: _____

_____ _____

Signature of Patient/Guarantor **Date**

Medical History Screening Information

Patient Name: _____

Date: _____

Circle Yes or No

Do you or your immediate family member(s) have:

	Self	Family
Cancer?	yes/no	yes/no
Diabetes?	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

In the past 6 months have you had or do you currently experience:

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

Circle Yes or 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

Date of last physical exam _____

Please list past surgeries:	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

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

Image Type / Facility Location	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

Please list any fractures:	**Date**
_____	_____
_____	_____
_____	_____

Have you had cortisone steroid injections?

If yes, where on body?_____

How many? _____

When? _____

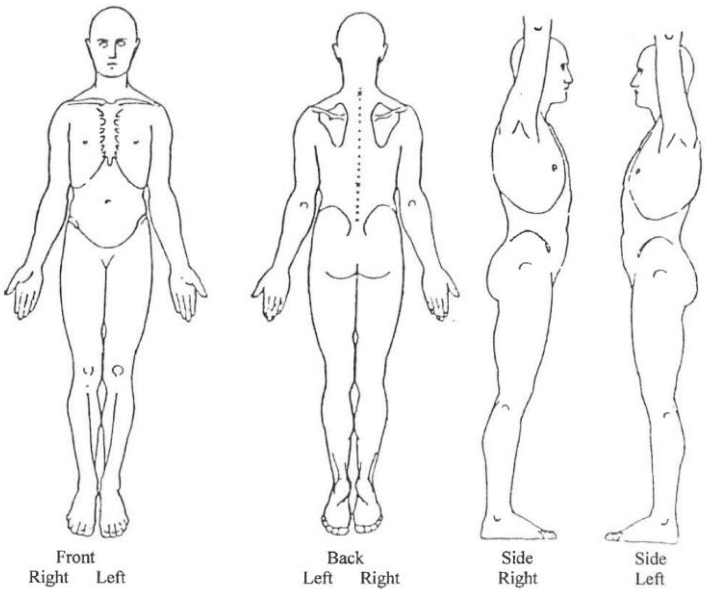
History of Present Condition

Patient Name: _____

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