PLEASE SIGN BY EACH "X"

Excel Physical Therapy, LLC

DATE:_____/_____/_____

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED

I authorize payment of medical benefits to Excel Physical Therapy, LLC for these services and all future claims.	I authorize the release of medical information necessary to process this claim and all future claims.	I have been provided with the Notice of Privacy Practices for Excel Physical Therapy, LLC and have had the opportunity to review it.
X _____	X _____	X _____
Signed (Insured or Authorized Person)	Signed (Insured or Authorized Person)	Signed (Insured or Authorized Person)

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Nickname_ _____

Mailing Address _____ City _____ State _____ Zip _____

Sex (circle one): Male Female

Date of Birth:_____/_____/_____

Home Phone: ( )_____Y _____

Marital Status (circle one): S M X D W

Currently Employed? YES NO

Cell Phone: ( )_____Y _____

Soc. Sec. Number:_____Y_____Y _____

Employer _____

Work Phone: ( )_____Y _____

Email:_____

Preferred Reminder Method: O Voicemail O Text Message O Email

SPOUSE / RESPONSIBLE PARTY

Last Name _____ First Name _____ Middle Initial _____ Nickname _____

Mailing Address _____ City _____ State _____ Zip _____

Sex (circle one): Male Female

Date of Birth:_____/_____/_____

Home Phone: ( )_____Y _____

Marital Status (circle one): S M X D W

Currently Employed? YES NO

Cell Phone: ( )_____Y _____

Soc. Sec. Number:_____Y_____Y _____

Employer _____

Work Phone: ( )_____Y _____

EMERGENCY CONTACT AND/OR NEXT OF KIN / REFERRING PHYSICIAN

Name: _____ Relationship: _____ Phone: ( )_____Y _____

Physician Last Name: _____ First Name: _____ Phone: ( )_____Y _____

INSURANCE INFORMATION

In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be completely filled out.

Does the Patient have health insurance? (circle one) YES NO

Date of Injury or Onset:_____/_____/_____

Is this visit related to an accident? (circle one) WORK COMP AUTO OTHER

Claim Number: _____

PRIMARY INSURANCE CARRIER

Company Name:_____

Address:_____

City _____ State _____ Zip _____

Phone: ( )_____Y_____

ID# / Subscriber Number _____ Policy / Group Number _____

Policy Holder Name:_____

OTHER INSURANCE CARRIER

Company Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: ( )_____Y _____

ID# / Subscriber Number _____ Policy / Group Number _____

Policy Holder Name: _____

MEDICAL SCREENING QUESTIONNAIRE FOR PHYSICAL THERAPY SERVICES

Date:_____ Time:_____:_____AM/PM Date of Birth: _____/_____/_____ AGE: _____
Legal Name:_____ Nickname: _____ Gender: □ M □ F
HEIGHT: _____ft _____in WEIGHT: _____# Dominant Hand: □ R □ L
How did you hear about us? □Physician:_____ □Website □ Word of Mouth:_____ □Other:_____

PAST/CURRENT MEDICAL HISTORY INCLUDES: Please Circle All That Apply

Cancer	Blood disorder	Osteoarthritis	Endometriosis
Diabetes I or II	Blood clots/DVT	Rheumatoid Arthritis	STD
Kidney problems	Bone/joint infection	Fibromyalgia	Pelvic inflam. disorder
Bladder issues/UTI	Addiction	Migraines/Headache	Pregnancy
Liver problems	Depression	Lung problems	Vision/Eye problems
Stroke	Steroid Use	Allergies	Hepatitis
High Blood Pressure	Asthma	Seizures/Epilepsy	Illness/Infection
Heart problems	Tuberculosis	Ulcers	Multiple Sclerosis
Angina/Chest Pain	Thyroid problems	Pneumonia	Metal/Implants
Pacemaker	Osteoporosis/penia	Smoker	Muscular Dystrophy
Low Blood Sugar/hypo-glycemia	Circulation/vascular problems	Broken bones/fractures Memory Loss/Head Injury	Parkinson Disease Other:

ARE YOU CURRENTLY OR HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING:
Please Circle All That Apply

Fatigue	Difficulty sleeping	Numbness/tingling	Joint pain/swelling
Weight loss/gain	Loss of Sensation	Difficult eating/swallowing	Difficulty with mobility
Pain at night or rest	Headaches	Chest pain	Vision considerations
Fevers/Chills/Sweats	Poor balance	Palpitations	Hearing problems
Nausea/Vomiting	Falls	Menstrual changes	Depression
Muscle weakness	Dizziness/lightheaded	Bowel/Bladder issues	Appetite Change
Shortness of Breath	Fainting	Heartburn/indigestion	Cough

Are there any customs/religious beliefs that may affect care? □Y □N
Are you sensitive to (circle): □Heat □Cold □Light □Noise other:_____
Are you allergic to any medications? □Y □N Anti-inflammatories? □Y □ N
Please explain anything checked/noted above: _____
_____
Please list all current medications, supplements, and previous medications taken on consistent basis: _____
_____
Past surgical history (list all & dates): _____
List any daily activities you are experiencing difficulties with: _____
Have you had Physical Therapy or other therapies before? □Y □N For your current complaint? □Y □N
What are your goals for physical therapy: _____
_____
Additional Comments: _____
_____

Patient Signature:_____Date:_____
For Excel PT:
VITALS: Temp: _____°F
HR: _____bpm
BP: _____/_____
RR: _____ Initials: _____

EXCEL
PHYSICAL THERAPY
JACKSON HOLE, WYOMING

Please initial each statement as you read and understand the terms.

_____**CONSENT FOR TREATMENT:** I hereby consent to recommended and/or performed examination & treatment that has been deemed necessary or desirable by personnel of Excel Physical Therapy, LLC. I do not hold Excel Physical Therapy, LLC facilities or personnel responsible for any injury, condition or lack of progress that may be incurred throughout the physical therapy treatment process.

_____**RELEASE OF INFORMATION/PATIENT RIGHTS:** I certify that the information given by me in requesting treatment, reporting symptoms or assigning payment is correct. I authorize and request Excel Physical Therapy, LLC to furnish and release any medical or personal information to be disclosed or used only to benefit my current injury/condition or to obtain payment if necessary. Under the services of Excel Physical Therapy, LLC, federal regulations protect my confidentiality and patients rights for non-discriminatory treatment by a licensed physical therapist.

_____**INSURANCE:** I understand that Excel Physical Therapy, LLC will bill the insurance company that I am currently contracted with and that I am responsible for the remaining amount that is or may not by covered. ***We highly recommend you call your insurance and know your coverage.*** Please be aware that in some cases, services provided or supplies may be considered "non-covered" by your insurance company or policy in full so that you understand what services will be covered, what your visit allotment and/or deductible is, and what you will ultimately be responsible for.

_____**FINANCIAL AGREEMENT:** I fully understand that I am financially responsible for all charges incurred. The undersigned agrees, whether signing as agent or as patient, to pay the account of Excel Physical Therapy, LLC in accordance with the regular rates and terms of the clinic. Should the account be referred to any attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense incurred by the clinic. I may pay total balance due at any time without penalty or additional finance charge. **Returned** Checks. A $25.00 **fee** will be charged for all **returned** checks.

_____**CANCELATION & NO SHOW POLICY:** I agree to pay a $75 cancelation fee to Excel Physical Therapy if I do not call within 24 hours to cancel my scheduled appointment. If you do not show up to your appointment and have not called to cancel, the cancelation fee will automatically be applied. This fee cannot be billed to insurance. If you no call no show to three appointments, you will be removed from any future appointments and will only be able to make same day appointments. This is to ensure optimal scheduling availabilities for all of our patients.

The undersigned certifies that they have read the foregoing, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

_____ By initialing I am acknowledging I have received the insurance information sheet to help me know my benefits, and follow up with my insurance provider for benefits.

SIGNED: DATE:

NAME (PRINTED):

WITNESS: