

Excel Physical Therapy, LLC

DATE: ____/____/____

PLEASE SIGN BY EACH "X"

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.

X _____
Signed (Insured or Authorized Person)

I authorize the release of medical information necessary to process this claim and all future claims.

X _____
Signed (Insured or Authorized Person)

I have been provided with the Notice of Privacy Practices for Excel Physical Therapy, LLC and have had the opportunity to review it.

X _____
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: Voicemail Text Message 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

OTHER INSURANCE CARRIER

Company Name: _____	Company Name: _____
Address: _____	Address: _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone: () _____ Y _____	Phone: () _____ Y _____
ID# / Subscriber Number _____	ID# / Subscriber Number _____
Policy / Group Number _____	Policy / Group Number _____
Policy Holder Name: _____	Policy Holder Name: _____