



Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. Completing this information now will help us start your first visit without delay. All information will be confidential.

Date _____ Patient name _____
First MI Last

SSN _____ - _____ - _____ Birthdate _____ Home phone _____ Cell phone _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Check appropriate box: Minor Single Married Widowed

Check appropriate box: Male Female

Occupation _____ Employer/school _____ Work phone _____

Address _____ City _____ State _____ Zip _____

Who may we thank for referring you? _____

Person to contact in case of emergency _____ (relationship) _____ Phone _____

Referring physician _____ Diagnosis or part of body being referred for _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Birthdate _____ SSN _____ - _____ - _____

Employer _____ Work phone _____

Was this injury related to a WORK, AUTO or SCHOOL accident? Yes No

If YES, please check one: work auto school

If YES, DATE OF INJURY _____

If AUTO related, are you currently being treated by a chiropractor? Yes No

TURN OVER

Primary Insurance Information

Insurance company _____
Insurance address _____ City _____ State _____ Zip _____
Insurance phone _____ Adjustor name (if applicable) _____
ID or claim # _____ Group # _____
Name of insured _____ Relationship to patient _____
Birthdate _____ SSN _____ - _____ - _____

Secondary Insurance Insurance

Insurance company _____
Insurance address _____ City _____ State _____ Zip _____
Insurance phone _____ Adjustor name (if applicable) _____
ID or claim # _____ Group # _____
Name of insured _____ Relationship to patient _____
Birthdate _____ SSN _____ - _____ - _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- Home Telephone _____ Work Telephone _____
- OK to leave detailed message OK to leave a detailed message
- Leave message with a call back number only Leave message with call back number only

Financial Agreement and Office Policy

I authorize release of all medical records concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Insurance benefits payable directly to me, are hereby assigned to Excel Orthopedic Rehabilitation for application to the patient's bill. In the event that the patient's insurer denies medical benefits, coverage, or payment in full or at all, consent is hereby authorized to allow Excel Orthopedic Rehabilitation to appeal such decisions on the patient's behalf.

I understand that a 24-hour advance notice is required for cancellation of an appointment. If the required notice is not given, I may be charged a fee of \$40, in which will be solely my responsibility and no portion will be billed to my insurance carrier.

I understand that a fee of \$40 will be charged to me for any returned checks and that I am liable for payment.

Please be advised that unless you have Medicare, we are not in-network with your insurance company, but as a courtesy we will submit your claims for you. If you have Medicaid as a secondary, you understand we do not participate and agree to pay the 20% Medicare does not cover. If you have a second insurance carrier, we will submit to that carrier. Once your primary and secondary companies have processed your bills, you will be responsible for any balance remaining. The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Excel Orthopedic Rehabilitation. I understand that I am responsible for any charges billed to and not covered by any insurance carrier(s), including any deductible, coinsurance, for visits over coverage limitations, for no prescription or MD signed plan of care. Should your account be referred for collections or an attorney, the undersigned agrees to pay costs of collection, including attorney fees and interest. The undersigned certifies that he/she has read and understands the foregoing, authorizes to execute the above, and accepts the terms.

Patient signature (or guardian if minor)

Date