EXCEL PHYSICAL THERAPY Getting Better Together

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Referring Physician: _____ Date: _____

Do you have a follow up appointment with your doctor: (Select one) if Yes, when? _____

Primary Care Physician: _____Diagnosis/Body Part: _____ Onset Date: _____

Weight: _____ Height: _____Age: _____ Have you ever had any of the following conditions? Circle all that apply:

Anemia	(Select one)	Polio	(Select one)
Arthiritis	(Select one)	Shortness of Breath	(Select one)
Asthma/Bronchitis	(Select one)	Heart Disease	(Select one)
Cancer	(Select one)	Angina/Chest Pain	(Select one)
Diabetes	(Select one)	Stroke	(Select one)
High Blood Pressure	(Select one)	Are you Pregnant?	(Select one)

Please list all surgeries, including dates: _____

Do you, or have you recently and/or currently experiencing any of the below symptoms in relation to the condition you are coming here for? Please briefly explain _____

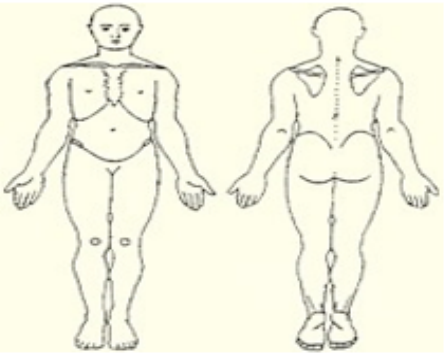
Nausea/Vomiting	(Select one)	Dizziness/Fainting Spells	(Select one)
Fever/chills/sweats	(Select one)	Night Pain	(Select one)
Unexplained weight change	(Select one)	Bowel or bladder changes	(Select one)
Numbness or tingling	(Select one)	Headaches	(Select one)
Muscular weakness	(Select one)		

Please check any tests/procedures that have been done for your current condition. If know, report the findings.

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ EMG ☐ Blood Work ☐ Bone Density ☐ Other

Briefly describe the history of your current injury and your primary complaint: _____

Please indicate the location of your symptoms:



Please rate the severity of your pain on a scale of 0 - 10, where 0 is no pain and 10 is the most severe pain.

Right Now	(Select one)
At Worst	(Select one)
At Best	(Select one)

Check the boxes below which best describes you pain:

Aching		Localized	
Burning		Numbness/Tingling	
Constant		Sharp	
Dull		Shooting/Radiating	
Intermittent		Throbbing	

PMH Questionnaire has been read and reviewed by Physical Therapist: Initials/License No. _____

PATIENT DEMOGRAPHICS

Patient name: _____ Home Phone: _____ Cell Phone: _____

Address: _____Apt No._____ City:_____ State: _____ Zip: _____

Birthdate: _____ SSN _____-_____-_____ Email Address: _____

Check appropriate box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Widowed** **Check appropriate box:** ☐ **Male** ☐ **Female**

Occupation: _____ Employer/School Name: _____ Work phone: _____

Who may we thank for referring you? _____

Emergency Contact:_____ Relationship: _____ Phone No. _____

INSURANCE INFORMATION

Name of Primary Insurance: _____ Name of Secondary Insurance: _____

Primary Insurance ID No. _____ Secondary Insurance ID No. _____

Was this injury related to a Work, Auto or School accident? (Select | If Yes, please circle one (Select one)

If Yes, Date of injury_____ If Auto related, are you currently being treated by a chiropractor? (Select on

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

___ I authorize the release of my medical records concerning my and/or dependent's health care, advice and treatment provided for the purpose of evaluating and obtaining reimbursement for services rendered.

____ In the event the insurance payer denies my claims I hereby give Excel Physical Therapy consent to appeal such decisions on my behalf.

____ In the event I received checks directly from my insurance carrier for services rendered. I agree to forward those checks to Excel Physical Therapy to be credited to my account accordingly.

____ It is my responsibility to provide accurate insurance information. In the event the information provided is incorrect, I accept full financial responsibility. I understand that a fee of $45 will be charged to me for any returned checks and that I am liable for payment.

____ Should your account be referred to a debt collection agency or an attorney, I agree to pay the incurred costs of the agency and/or attorney, a $25.00 administrative fee and 18% interest after 60 days.

____ By providing my email address, I consent to receive periodic emails from Excel Physical Therapy. I will always have the option to opt out.

____ As a courtesy, Excel Physical Therapy will verify insurance benefits. It is my responsibility to know my in network financial responsibility.

CONSENT FOR CARE

I consent to physical therapy treatment as ordered by my physician's orders and administered by Excel Physical Therapy. I acknowledge that no guarantees have been made regarding results from rendered treatment.

GUARANTEE OF ACCOUNT

For services rendered to (patient's name) by Excel Physical Therapy, I agree to pay the full bill for all charges not paid to Excel Physical Therapy by all insurance carriers or any balance due not covered by insurance.

TREATMENT OF MINORS

Regarding the treatment of minors in our facilities **– It is recommended the patient's parent or guardian remain present during the initial consultation and all subsequent visits.** In case you have questions, it is recommended to remain physically present during all physical therapy visits so the physical therapist can explain the findings/goals/ treatment plan and progress personally. The parent or guardian could be in waiting room and does not have to be physically present in the gym. Should you have any questions, please contact Human Resources at 201-881-7326.

PHOTOGRAPHY POLICY

At Excel Physical Therapy, we ask that you refrain from taking any photography or videography while in the physical therapy gym. Please understand that this is to maintain the privacy of all our patients and within our duty to uphold the laws of the Health Insurance Portability and Accountability Act (HIPAA). If you would like to take a picture or video, please speak with your physical therapist to get consent and to ensure that there are no other patients in the background. Also, if you have any questions, please speak with your physical therapist. By signing this form, you acknowledge this policy and agree to refrain from photography. Thank you for your cooperation as we strive to maintain a comfortable treatment environment for everyone.

HIPAA – NOTICE OF PRIVACY

I authorize release of all medical records concerning my (or my dependent's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. If you have questions regarding the information in the Excel Physical Therapy's Notice of Privacy, please contact our Privacy Officer at 201-881-7326.

_____

Patient/Guardian or Parent (if patient is a minor) signature Date

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Credit Card / ACH Debit Payment Authorization

Patient Name: _____

Billing Address: _____
(street number) (street name, town, state) (Zip code)

Checking / Savings Account

☐ Checking ☐ Savings

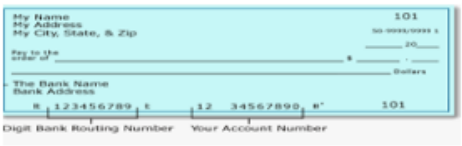
Name on account _____

Bank Name _____

Account Number _____

Bank Routing Number _____

Bank City/State _____



Credit Card Account

☐ VISA ☐ AMEX ☐ MASTERCARD ☐ DISCOVER

Cardholder Name _____

Account Number _____

Account Number _____

Exp. Date _____

CVV (3-digit no. on back of card) _____

AMEX (4 digits on front of the card) _____

By signing this form, you give Excel Physical Therapy permission to regularly debit your account for services rendered. A charge will appear on your credit card or bank statement. A receipt will be provided to you upon request. You agree that no prior notification will be provided unless the agreed amount changes. In which case you will receive notice form us prior to the payment being collected.

Bank Account/Cardholder's Signature:_____ Date: _____

Please sign below if you DO NOT want to give Excel Physical Therapy your credit card number, and agree to pay your/your dependent's co-pay at the time of services rendered by cash, check, Visa, MasterCard, Discover, or AMEX.

Signature: _____ Date: _____

NOTICE OF CONFIDENTIALITY

The information contained in this form is confidential and may be privileged and/or contain confidential health information that is legally protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and related regulations. Thank you.