EXCEL PHYSICAL THERAPY

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PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name _____ Referring Physician _____ Date _____

Do you have a follow up appointment scheduled with your doctor? (select one) If yes, when? _____

Primary Care Physician _____ Diagnosis/Body Part _____ Onset Date _____

Height _____ Weight _____ Age _____ Have you ever had one of the following conditions? (Circle all that apply)

Anemia	(select on		Diabetes	(select on		Heart Disease	(select or
Arthritis	(select on		High Blood Pressure	(select on		Angina/Chest Pain	(select or
Asthma/Bronchitis	(select on		Polio	(select on		Stroke	(select or
Cancer	(select on		Shortness of Breath	(select on		Currently Pregnant	(select or

Please list all surgeries, including dates: _____

Please list current medications and dosage: _____

Have you recently or are you currently experiencing any of the below symptoms **related to the condition that you are coming here for**? (Circle all that apply):

Nausea/Vomiting	(select c		Numbness/Tingling	(select c		Night Pain	(select c
Fever/chills/sweats	(select c		Muscular weakness	(select c		Bowel or bladder changes	(select c
Unexplained weight change	(select o		Dizziness/Fainting	(select c		Headaches	(select c

If yes, please briefly explain: _____

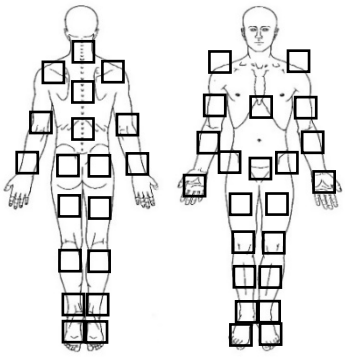
Please circle any tests/procedures that have been performed for your current condition.

X-Ray		**MRI**		**CT Scan**		**Bone Scan**		**EMG**		**Blood Work**		**Bone Density**		**Other**	

If known, briefly report the findings:

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

Please indicate the location of your pain on the model below:



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)

Select which box(es) below that best describe(s) your 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. _____

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PATIENT DEMOGRAPHICS

Patient Name _____ Home Phone _____ Cell Phone _____

Address _____ Apt, Suite or Unit No. _____

City _____ State _____ Zip Code _____

Birthdate _____ SSN _____ - _____ - _____ Email _____

Gender: (select one) Marital Status: **Minor** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐

Occupation _____ Employer/School Name _____ Work Phone _____

How did you hear about EXCEL?

☐ **Advertisement** ☐ **Insurance List** ☐ **In-Person Event** ☐ **Internet Search**

☐ **I'm a returning patient** ☐ **My coach or athletic trainer** ☐ **My doctor referred me**

A friend told me about EXCEL (Please name friend): _____

I know an EXCEL employee (Please name employee): _____

Other (Please explain): _____

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 one) If yes, please select: (select one)

If yes, what was date of injury? _____ If auto related, are you currently being treated by a chiropractor? (select one)

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 my 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.

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POLICY AGREEMENTS

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 FOR ACCOUNT

For services rendered to **(patient named below)** 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 highly recommended that the patient's parent or guardian remain present during the initial consultation and all subsequent visits.** It is highly encouraged to remain physically present during all physical therapy visits so the physical therapist can explain the findings/goals/treatment plan and progress personally and address any questions regarding the plan of care. A parent or guardian may remain in the 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

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 first. In the instance a photograph is requested to be taken by either a patient or EXCEL staff member for marketing purposes, you have the right to decline.

HIPAA – NOTICE OF PRIVACY

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. 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.

By signing this form, you acknowledge that you have read and understand the above policies.

First Name (printed) _____ Last Name (printed) _____

Signature _____ Date _____

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CREDIT CARD/ACH DEBIT PAYMENT AUTHORIZATION

Patient Name _____

Billing Address _____ Apt, Suite or Unit No. _____

City _____ State _____ Zip Code _____

Checking/Savings Account

Please select one: (select one)

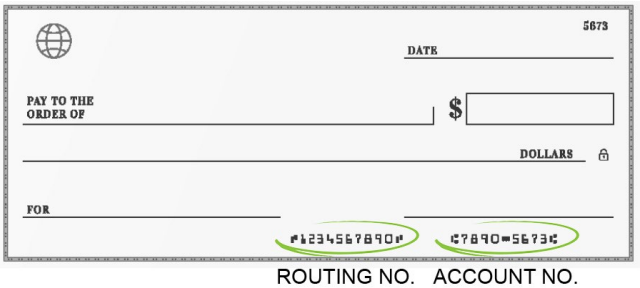
Name on account _____

Bank Name _____

Account Number _____

Routing Number _____

Bank City/State _____



ROUTING NO. ACCOUNT NO.

Credit Card Account

Please select one: (select one)

Cardholder Name _____

Account Number _____

Expiration Date _____

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

AMEX (4 digit no. on front of 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.

First Name (printed) _____ Last Name (printed) _____

Bank Account/Card Holder 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.

First Name (printed) _____ Last Name (printed) _____

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.