EXCELRATION PHYSICAL THERAPY

Patient Information Form

Please answer all questions thoroughly. This form is required by your insurance carrier.

Name _____ Date _____

Reason for Visit

What is your injury/illness? _____

What problems are you having related to this injury/illness? _____

_____

What are your goals for therapy? _____

_____

Have you had surgery related to this injury/illness? □ Yes □ No If yes, what type & when? _____

What other surgeries have you had? _____

Have you had x-rays, MRI, CT scan or other imaging? □ Yes □ No If yes, please explain: _____
If you have had recent imaging, when did it occur? _____

This injury/illness a result of: work car accident sport other (Circle one)

Have you had a previous injury/illness to this site? □ Yes □ No If yes, please explain: _____

Please rate your level of pain (circle one): No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Medical History

Have you had previous head or neck injuries? □ Yes □ No If yes, please explain: _____

Have you had previous physical therapy or chiropractic visits? □ Yes □ No
If yes, was that course of treatment successful? _____

What is your height? _____ Weight? _____

Do you have any metal implants? □ Yes □ No If yes, where? _____

Are you diabetic? □ Yes □ No Are you pregnant? □ Yes □ No

Do you have any allergies? □ Yes □ No If yes, to what? _____

Do you have any current or past heart problems? □ Yes □ No If yes, please explain _____

Do you have high blood pressure? □ Yes □ No

Do you have or have you ever had cancer? □ Yes □ No
If yes, when? _____

Have you had a seizure? □ Yes □ No
If yes, when? _____

What other health care providers are you seeing for this condition? _____

Please list any medications you are taking as well as the dosage prescribed: _____

_____

Is there anything else you would like to share with us that may be valuable in providing your care? _____

_____

Consent Form

Authorization for Treatment

I hereby voluntarily consent to and authorize the performance of an examination and treatment according to the referring physician's prescription and recommendations, and within the judgment of the attending therapist to be advisable for my care. I am aware that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me regarding the result of examination, tests, or treatments. I understand that if specific treatment procedures are required, I will be asked to give specific consent to them.

Without limitation, the foregoing extends to the staff of Excel-R-ation Physical Therapy, as well as any professionally licensed therapist contracted by Excel-R-ation Physical Therapy. I understand and agree that pursuant to the Michigan Department of Public Health Code, Excel-R-ation Physical Therapy may require an HIV or AIDS test to be performed if any employee or contracted professional sustains a percutaneous, mucous membrane, or open wound exposure to my blood or other body fluids

Authorization to Pay Insurance Benefits

I hereby authorize payment directly to Excel-R-ation Physical Therapy of any insurance benefits or other payments by third parties otherwise payable to me, but not to exceed Excel-R-ation Physical Therapy's customary charges for the services provided. I understand that I am responsible for all charges that exceed my insurance benefit(s) or third party payments.

Release of Information

In the event that Excel-R-ation Physical Therapy needs to give or receive information or service, I agree that Excel-R-ation Physical Therapy may give information in the medical record about me to any person involved in my medical care to any third party responsible for paying for my care, including, without limitation, records relative to claims, my employer, and any workers compensation insurance carrier engaged by my employer and to any outside peer review or auditing agency engaged by a third party payer to review my medical records. A copy of my record may be sent to my family physician and/or any physician, hospital, home health provider, insurance company or other health care provider who participated in my care, or who may provide for my care following treatment. This information may include information about communicable diseases and infections, including but not limited to HIV, AIDS, and AIDS related complex. Excel-R-ation Physical Therapy may also obtain any information about me, which is needed in order to treat me, from other persons or health care facilities that have provided care to me.

Excel-R-ation Physical Therapy may also give information to any third party who may be responsible for payment of my account. Excel-R-ation Physical Therapy may release my medical record to any collection agency or attorneys engaged by Excel-R-ation Physical Therapy to collect any amounts due for services provided to me at the Excel-R-ation Physical Therapy. I agree that those collection agencies or attorneys may introduce my medical record as necessary in any court action to collect any amounts due for services rendered to me at Excel-R-ation Physical Therapy. The consent for release of information given in this agreement shall remain in effect as long as is necessary to effectuate the purposes for which it is given.

Rights of Privacy under the Federal Privacy Standard

I acknowledge that I have had the right to review or receive a copy of Excel-R-ation Physical Therapy's *Notice of Privacy Practices* that describes how medical information about me may be used and disclosed, and how I can get access to this information. The *Notice of Privacy Practices* complies with patient privacy and confidentiality regulations contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the final privacy regulations enacted by the Department of Health & Human Services in the Security of Individual Health Information Standards.

Patient Representative or Agent

Where "I" is used in this agreement, it refers to both the Patient and the Patient's representative or agent. Excel-R-ation Physical Therapy has no duty to investigate the authority of the Patient's agent or representative and is relying on the representative or agent that he or she has the authority required to enter into this agreement.

Patient or legal representative signature	Date
Witness	Date

EXCELERATION PHYSICAL THERAPY

Patient Update:

Initial below if no changes have been made to your information

_____ _____
Initials date

General Information Form

A. Patient Information

Patient Name _____ Date of Birth _____
(Last) (First) (Middle)
SS# _____

Address _____ ☐ Male ☐ Female

City/State/Zip _____ Marital Status _____

Primary Phone _____ ☐cell ☐home Secondary Phone _____

Email Address for us to send appointment reminders (Optional) _____

1. How did you hear of our clinic? ☐ friend ☐ family member ☐ My doctor ☐ other _____

2. Is this a work related injury? ☐ Y ☐ N **OR** Is this injury from a motor vehicle accident? ☐ Y ☐ N (Complete **Section F** below)

B. Emergency Contact (or parent/guardian name/s for minors)

Name _____ Phone _____
(Relationship)

C. Employer Information

Employer _____ Phone _____

Address _____ City/State/Zip _____

D. Physician Information

Primary Doctor _____ Referring Doctor _____

1. Have you recently been receiving home health care or hospice care?* ☐ Y ☐ N If so, when were you discharged? _____
*You must have been discharged from home health care for Medicare to allow outpatient PT.

2. Have you received chiropractic or other therapy treatment during your current plan year?** ☐ Y ☐ N If yes, how many visits? _____
**Please check your insurance for limits/copays. Some plans consider chiropractic under same benefit limits as physical therapy & other therapy treatments.

E. Insurance Information

*****PLEASE VERIFY YOUR PHYSICAL THERAPY BENEFITS WITH YOUR INSURANCE COMPANY. IT IS IMPORTANT THAT YOU UNDERSTAND YOUR PT COVERAGE*****

1. Primary Insurance _____ Insured's Name _____

Contract ID# _____ Group# _____

Insured's DOB _____ Relationship _____

2. Secondary Insurance _____ Insured's Name _____

Contract ID# _____ Group# _____ Insured's DOB _____ Relationship _____

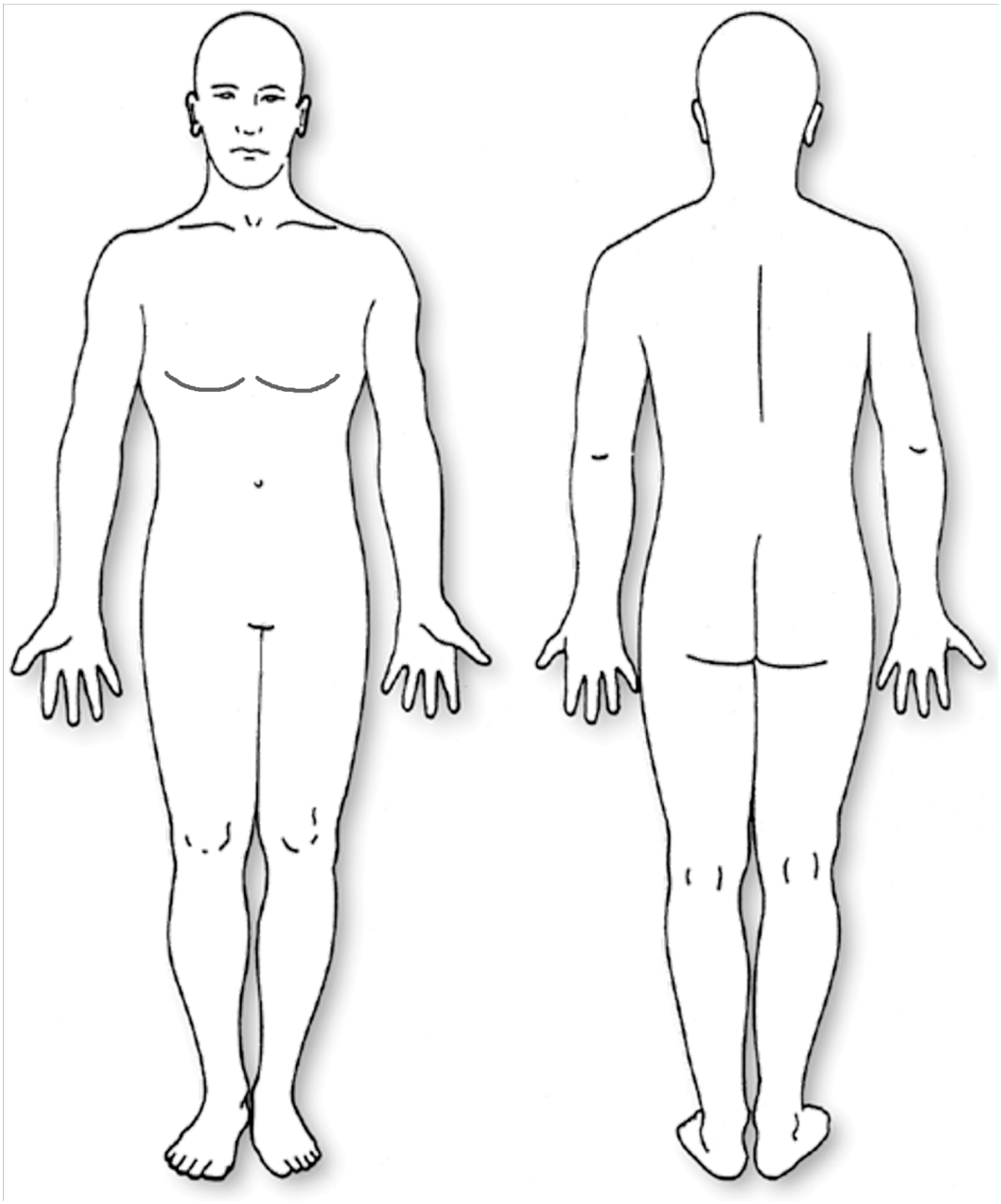
F. Injury Insurance Information

Insurance Carrier _____ Contact Name _____

Phone Number _____ Claim # _____ Date of Injury _____

EXCELRATION
PHYSICAL THERAPY

Please shade the area of the drawing to indicate your area of pain or injury.



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EXCEL-R-ATION
PHYSICAL THERAPY

Financial Policy

It is the policy of Excel-R-ation Physical Therapy to have a Financial Policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care while minimizing administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services. We expect that our patients will be as actively involved in their financial responsibilities as they are with their rehabilitation and recovery.

No Shows
It is our desire to be able to offer convenient and timely appointments for physical therapy services at Excel-R-ation. So that we can help you maximize your recovery, we ask that you please keep your appointments that are scheduled, or call prior to the appointment time to reschedule. We charge **a $25 no-show fee** to the patient's account for appointments that are not cancelled prior to the appointment time. This fee is to be paid *prior* to the patient's next visit.

Insurance & Billing
Our office participates with numerous insurance companies and managed health care programs. For patients who are members of one of these plans, our business office will submit a claim for services rendered. Patients must complete all necessary insurance information, including any special forms, and bring their insurance card to the initial visit. If insurance changes during the course of treatment, the patient is responsible to immediately provide our office with new insurance information.

Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company's member services department. (Phone number can typically be found on the insurance card.)

If a patient has insurance that we do not participate with, **payment in full is expected at the time of service.**

Patients without Insurance
Patients who do not have insurance or whose benefits have been exhausted are expected to pay for professional services **at time of service** unless prior arrangements have been made. We offer a discounted rate for "cash pay" appointments as following:

Initial Examination:	45-60 minutes	$125
Follow-up Visits:	30 / 45 minutes	$60 / $90

This is a discount from our retail fees that we charge the insurance companies.

Worker's Comp or Auto Injuries
Patients must inform our office **prior to treatment** if treatment is for an auto or work-related injury. If our office bills the patient's private insurance company for therapy and later is informed that the incident is work or auto related, the patient may be responsible for any amounts the insurance company does not cover.

Physician Referrals
It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice **before the visit.** Visits may be rescheduled, or the patient may be financially responsible for payment for the visit due to the lack of referral.

Please see other side
⇨ ⇨ ⇨

Patient's Financial Responsibility
It is the patient's responsibility to pay any deductible, co-insurance, co-payment, or any portion of the charges as specified by the plan **at the time of service.** Any medical services not covered by an individual's insurance plan are the patient's financial responsibility and payment in full is due at the time of visit.

We bill participating insurance companies as a courtesy to our patients. If we have not received payment or a response to our billings from the patient's insurance company within 45 days of the date of service, the patient may be expected to pay the balance in full.

Minors
It is the policy of Excel-R-ation Physical Therapy that any patient age eighteen years or older will be financially responsible for all charges incurred. Excel-R-ation Physical Therapy does not get involved with divorce or separation situations. For any patient under the age of eighteen, the parent who accompanies the minor and signs the financial policy acknowledgment at their initial visit will be financially responsible for all charges incurred. For unaccompanied minors, payment arrangements must be approved by our office prior to each visit.

Financial Assistance
If a patient feels that he or she may require financial assistance, he or she must notify the receptionist before seeing the therapist, for referral to the appropriate individual. Payment plans are an option if the patient demonstrates the need to extend the account payment period and a commitment to pay the balance in full.

Returned checks
Excel-R-ation shall charge a returned check fee of $25.00 for all checks returned as "non-negotiable", "insufficient funds" or for any other reason, if the balance is paid within 7 days. If the balance remains unpaid after 8 or more days, a $35.00 fee will be charged.

Payment for professional services can be made with cash, check, MasterCard, Visa or Discover.

ASSIGMENT OF INSURANCE BENEFITS
I assign to Excel-R-ation Physical Therapy all rights to benefits, insurance proceeds, settlement payments, or judgments to which I may be entitled for rehabilitation services. I authorize Excel-R-ation Physical Therapy to submit a claim for payment on my behalf to the insurance carrier. I also give Excel-R-ation Physical Therapy the right to intervene in any lawsuit or other action brought to me, or on my behalf, to collect amount due to them.

UNPAID BALANCE
I agree to pay the unpaid balance on my account on the due date listed on my statement. I understand that if I do not pay the balance on time, a late fee of **$5 per month** will be added to my account balance for the first month, and **$10 per month thereafter**. I further understand if my account is unpaid after the listed statement due date, that Excel-R-ation Physical Therapy may send my account to collections, report my account information to credit reporting agencies, request a meeting through mediation or file a claim in small claims court. I understand that I am responsible for any additional filing, service or other fees associated with collecting my unpaid balance.

I understand that in the event that any unpaid balance is placed for collections with any third party collection agency, a $3.50 fee will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, and all other expenses so stated elsewhere. The authorized fee and the additional costs and charges listed above represent the actual costs incurred by Excel-R-ation Physical Therapy to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

See accompanying Acknowledgement Form for signatures.

EXCEL-RATION
PHYSICAL THERAPY

Policy Acknowledgement

_____

PATIENT NAME

Financial Policy

I have been provided a copy of the of the Excel-R-ation Physical Therapy Financial Policy. I have read it or have had it read to me, have had the opportunity to ask any questions, and agree to the terms.

I give permission for Excel-R-ation to speak to the following family members and/or representatives regarding my financial status and/or to discuss my bills and/or insurance benefits:

Name	Relationship
_____	Spouse
_____	_____
_____	_____

_____ _____

Patient Signature (or parent/guardian if minor) **Date**

.....

HIPAA Notice of Information Practices

I have been provided a copy of the of the Excel-R-ation Physical Therapy Notice of Information Practices. I have read it or have had it read to me and have had the opportunity to ask any questions.

_____ _____

Patient Signature (or parent/guardian if minor) **Date**

_____ _____

By Excel-R-ation witness **Date**