



Patient Information Form

PHYSICAL THERAPY • OCCUPATIONAL THERAPY • FITNESS CENTER

Date: _____

1420 Ashley Road • Boonville, Missouri 65233 • 660-882-6115

Name of Patient: _____ Marital Status: S M D W

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell Telephone: _____

Email Address: _____ Advance Directive? Yes/No (If yes, please provide copy)

Patient's Date Of Birth: _____ Age: ____ Patient's Sex: M/ F Patient's Social Security # _____

Patient's Employer: _____ Occupation _____

Employer's Address: _____ Work Phone: _____

Reason for treatment/Area affected: _____ Date of onset of symptoms: _____

Date of surgery (if applicable): _____ Referred by: Doctor: _____ Date Return to Physician: _____

Is injury a result of an accident: Yes/No. If Yes: Work/Auto/Other _____

Had other therapy or chiropractic treatment this year? _____

How did you hear about Excel Physical Therapy? Internet :__ Friend: _____ Doctor: _____ Other: _____

Primary Insurance

Secondary Insurance

Name of Insured:		Relationship to Patient:		Name of Insured:		Relationship to Patient:	
Birth Date and SS number:		Employer:		Birth Date and SS number:		Employer:	
Address (if different from patient's):				Address (if different from patient's):			
Insurance Company/ Auto Carrier:				Insurance Company/ Auto Carrier:			
ID Number:		Group Number		ID Number:		Group Number	
Insurance Claims Adjuster/ Phone Number				Insurance Claims Adjuster/ Phone Number			

Person To Call In Case Of Emergency

Name:	Address:	Phone:	Relationship
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Although services may be covered by insurance, I understand I am fully responsible for payment for care I receive. I authorize payment of medical benefits to my physician for services rendered. I authorize the doctor or insurance to release any information required for services rendered by this office. I give Excel Physical Therapy and Sports Medicine Clinic permission to use a collection service, if by chance my account is 90 days over do.

Signed: _____ Dated: _____



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Consent for Treatment:

I recognize that I am suffering from a condition requiring athletic training, physical, and/or occupational therapy services and treatment. I hereby consent to the rendering of athletic training, physical, and/or occupational therapy services by Excel Physical Therapy & Sports Medicine Clinic, P.C., as described to me or as my physician or Excel Physical Therapy & Sports Medicine Clinic, P.C. determines as necessary. I understand that the practice of athletic training and/or physical/occupational therapy is not an exact science and that athletic training and/or physical/occupational therapy involves the risk of injury or even death. I acknowledge that no guarantees have been made to me about the outcome of treatment.

Consent of Disclosure (for Usage and/or Disclosure of Protected Health Information)

I hereby give consent to Excel Physical Therapy & Sports Medicine Clinic, P.C. and all health care providers furnishing care within Excel Physical Therapy & Sports Medicine Clinic to use and disclose my protected health information for the purposes of treatment, payment, and health care operations. You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address listed above. This may be delivered in person or by mail, but will only be effective when actually received. Your cancellation will not be effective to the extent that other or we have acted in reliance upon this consent.

You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment, or health care operations. We are not required to grant your request, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by: 1) viewing the copy that is available in our waiting room, 2) by going to our website www.excelpt.net, and 3) by asking for a copy from our Privacy Officer, Jill McCormick, PT, ATC.

Assignment of Insurance Benefits

I hereby assign Excel Physical Therapy & Sports Medicine Clinic, P.C., (1) all insurance, Medicare, Medicaid, and other private or governmental benefits payable for my treatments and care; and (2) all rights to payment and all money paid for any claim related to the reasons for which I am being given athletic training, physical, and/or occupational therapy service and treatment. Anyone paying or receiving money for my benefits or claims shall pay the money directly to Excel Physical Therapy & Sports Medicine Clinic, P.C., for payments of my bills. I understand that I am financially responsible for all charges not covered by my insurance or other third party payers and that any balance after insurance or third party payment has been made is due within thirty (30) days. After 30 days all past due accounts are subject to an additional 1.5% financing fee compounded monthly as well as a monthly \$15 late fee. I have read and understand this form and the program it describes, and I do voluntarily request the right to participate in Excel Physical Therapy & Sports Medicine Clinic's rehabilitation program. I do hereby discharge, release, and hold harmless Excel Physical Therapy & Sports Medicine Clinic, P.C. and any of its personnel participating in this rehabilitation from any and all liability for damage of any kind or character resulting from any injury or condition I may suffer, or my result from such a rehabilitation program.

THIS FORM HAS BEEN EXPLAINED TO ME AND I SIGN IT VOLUNTARILY.

Participant Signature: _____ Date: _____

Excel Employee Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Cancellation of Consent to Disclose Information:

I hereby void the consent given above.

Print name of patient: _____

Signature: _____ Date: _____

If you are signing as the patient's representative:

Print your name: _____ Relationship: _____

Address for cancellation: Your cancellation will be effective, upon receipt, at the following address:



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HIPPA Notice of Privacy Practices Acknowledgement of Receipt

I have been provided with the Notice of Privacy Practices of Excel Physical Therapy Sports Medicine Clinic and understand that any questions or concerns regarding this notice may be directed to the Privacy Officer, Jill McCormick. If I chose to, or are not able to sign, a staff member will sign and date this acknowledgement for me. This acknowledgement will be filed in my records.

Patient Signature: _____ Date: _____

Witness: _____

24 Hour Cancellation Policy

Excel Physical Therapy & Sports Medicine Clinic, P.C asks that you kindly give at least 24 hours notice for cancellation or rescheduling. Please be aware that you are to give 24 hours notice or will result in a \$25.00 charge. Please be timely for all appointments. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated. When able, please schedule your appointments at least one week in advance to ensure the times that you need are available. Appointment times given one week do not automatically follow through to subsequent weeks. The patient and receptionist have discussed the importance of frequency and duration. Thank you for your cooperation.

Patient Signature: _____ Date: _____

Excel Employee Signature: _____ Date: _____



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Patient Medical History and Personal Fitness Questionnaire

The following questionnaire is used to gather information regarding your current and past medical status. Responses to these questions will provide you and our staff with the most appropriate information for safe and effective treatment.

Personal History:

Check each as it applies to you. Have you ever had:

- | | | | |
|---------------------|---------------------------|---------------------|---------------------------|
| T.B. | Yes ___ No ___ Unsure ___ | Allergy | Yes ___ No ___ Unsure ___ |
| Heart Attack | Yes ___ No ___ Unsure ___ | Convulsions | Yes ___ No ___ Unsure ___ |
| Angina | Yes ___ No ___ Unsure ___ | Paralysis | Yes ___ No ___ Unsure ___ |
| EKG Abnormalities | Yes ___ No ___ Unsure ___ | Leg Cramps | Yes ___ No ___ Unsure ___ |
| Emphysema | Yes ___ No ___ Unsure ___ | Headache | Yes ___ No ___ Unsure ___ |
| High Blood Pressure | Yes ___ No ___ Unsure ___ | Depression | Yes ___ No ___ Unsure ___ |
| Surgery | Yes ___ No ___ Unsure ___ | Shortness of Breath | Yes ___ No ___ Unsure ___ |
| Diabetes | Yes ___ No ___ Unsure ___ | Arm Pain | Yes ___ No ___ Unsure ___ |
| Stroke | Yes ___ No ___ Unsure ___ | Low Blood Pressure | Yes ___ No ___ Unsure ___ |
| Severe Illness | Yes ___ No ___ Unsure ___ | Indigestion | Yes ___ No ___ Unsure ___ |
| Hospitalized | Yes ___ No ___ Unsure ___ | Ulcers | Yes ___ No ___ Unsure ___ |
| Blackouts | Yes ___ No ___ Unsure ___ | Asthma | Yes ___ No ___ Unsure ___ |
| Gout | Yes ___ No ___ Unsure ___ | Hernia | Yes ___ No ___ Unsure ___ |
| Nervousness | Yes ___ No ___ Unsure ___ | Back Pain | Yes ___ No ___ Unsure ___ |
| Joint Problems | Yes ___ No ___ Unsure ___ | Chest Pain | Yes ___ No ___ Unsure ___ |
| Sleep Interference | Yes ___ No ___ Unsure ___ | Cancer | Yes ___ No ___ Unsure ___ |

Have you ever had physical therapy or currently receiving home health ___ yes ___ no. If so, please explain: _____

Have you ever had any orthopedic injuries, i.e. sprains, strains, fractures, etc? ___ yes ___ no. If so, please explain: _____

Have you ever had surgery? ___ yes ___ no. If so, for what? _____

Any other medical problems? If so, please describe: _____

Medical History:

Name of your family physician: _____ Date of last physical: _____

- Do you wear a pacemaker? ___yes ___no
- Do you know your resting blood pressure? ___yes ___no _____mmHg
- Do you know your resting heart rate? ___yes ___no _____BPM
- Have you ever had an exercise ECG? ___yes ___no
- Are you pregnant? ___yes ___no

Please list any medications your are currently taking: _____

Please list all drug allergies: _____

I certify that to the best of my knowledge the above answers are true and correct.

Signature: _____ Printed Name: _____