

CONFIDENTIAL MEDICAL HISTORY/EVALUATION

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____

Marital Status: S M D W Is this injury? Work or Auto related

Employer : _____ Phone #: _____ School : _____ FT PT

Date of Injury/Onset: _____ Referring MD: _____ Clinic _____

Clinic Address: _____ Phone: _____ Fax: _____

Primary Insured Name: _____ DOB: _____ SS#: _____

Insured Employer: _____ Phone: _____

Secondary Insured Name: _____ DOB: _____ SS#: _____

Emergency Contact Name: _____ Phone: _____

Do you have any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, Emphysema	_____	_____	Shortness of Breath/Chest Pain	_____	_____
Coronary Heart Disease	_____	_____	Do you have a pacemaker	_____	_____
High blood pressure	_____	_____	Heart Attack/Surgery	_____	_____
Stroke/TIA	_____	_____	Blood Clot/Emboli	_____	_____
Epilepsy/Seizures	_____	_____	Thyroid Trouble/Goiter	_____	_____
Anemia	_____	_____	Infectious Disease	_____	_____
Diabetes	_____	_____	Cancer or Chemo/Radiation	_____	_____
Arthritis/Swollen Joints	_____	_____	Osteoporosis	_____	_____
Varicose Veins	_____	_____	Gout	_____	_____
Sleeping Difficulties	_____	_____	Emotional/Psychological Problems	_____	_____
Bowel or Bladder Problems	_____	_____	Severe/Frequent Headaches	_____	_____
Vision/Hearing Difficulties	_____	_____	Dizziness or Faintness	_____	_____
Are you Pregnant?	_____	_____	Do you smoke?	_____	_____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I have received a copy of Excel Physical Therapy's financial and billing policy and I understand that I am responsible for any charges incurred. I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Excel Physical Therapy regardless of participation in or out-of-network. A finance charge of 1.5% will be assessed to your account 30 days after you have been billed and monthly thereafter if payment is not received. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

CANCEL AND NO SHOW POLICY: We take this subject seriously at our clinic because it can make the difference between whether or not you succeed in your treatment. We require **24 hours notice** in the event of a cancellation. There is a **\$25.00 charge** for a cancellation without proper notice. This charge is **NOT** covered by insurance and will have to be paid by you personally **AT YOUR NEXT VISIT.**
UNDER PENALTIES OF PERJURY, I CERTIFY THAT THE INFORMATION IS TRUE, CORRECT AND COMPLETE.

Patient/Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____