

PATIENT INFORMATION

Account Number _____ Date First Seen _____
(Month/Date/Year)

Patient Name _____ Diagnosis Code _____

Social Security # _____ - _____ - _____ Birth Date _____ Marital Status _____ Sex _____
(Month/Day/Year) (Male/Female)

Home Address _____
(Street) (City) (State) (Zip Code)

Home Phone # _____ Cell Phone # _____
(Area Code) (Area Code)

E-mail Address _____ School if Student _____

Patient Employer _____ Position _____

Employer Address _____ Work Phone # _____
(Street) (City, State, Zip) (Area Code)

Referral Physician _____ Phone # _____
(Area Code)

Treatment Area _____ Injury Date _____ Surgery Date _____
(Month/Day/Year) (Month/Day/Year)

Due to Auto Accident: Yes/No **Injury at Work:** Yes/No **Third Party Accident:** Yes/No **Sports Injury:** Yes/No

Attorney _____
(Name) (Street) (City, State, Zip) (Phone #)

EMERGENCY CONTACT

Spouse/Parent/Friend _____
(Circle One)

Address _____ Phone # _____

Employer _____ Position _____

Employer Address _____ Phone # _____

INSURANCE INFORMATION

PRIMARY Company Name _____ Phone # _____

Address _____

Policy # _____ Group # _____

Subscriber _____ Relationship to Patient _____

Medicare Assignment Yes No

SCNDARY Company Name _____ Phone # _____

Address _____

Policy # _____ Group # _____

Subscriber _____ Relationship to Patient _____

VERIFICATION

Date _____ Talked To _____ Phone # _____ Coverage Renewal _____
(Month/Day/Year) (Area Code) (Month/Day/Year)

Visit Limit Per Year _____ Insurance Pays _____ Deductible/Year _____ Amount Met _____

Copay/Visit _____ Annual Out-of-Pocket Met: YES/NO Amnt Met _____ Auth # _____

Ins. Plan Referral Required: YES / NO Verified By _____

1. I authorize the release of any medical information necessary to process this claim as well as to my physician(s).
2. I request payment of Government Benefits either to myself or to the party who accepts assignment.
3. I also authorize payment of medical benefits to the Physical Therapy provider for services described.
4. I consent to treatment and/or examination under the supervision of my attending Therapist.
5. I have received Excel Physical Therapy's Notice of Privacy Practices.

Patient's or Authorized Person's Signature
(Read Before Signing)

Date

