EXCEL
Physical Therapy of Naples

NEW PATIENT REGISTRATION

Print Full Name: _____ _____ _____ Date: ____ / ____ / _____
First *Middle* *Last*

SSN: _____-_____-_____ Date of Birth: _____/____/____ Age: _____ Gender: ___M ___F Single__ Married __

Local Address: _____ _____ _____ _____
P.O. Box / Street Address *City* *State* *Zip Code*

Out of State Address: _____ _____ _____ _____
P.O. Box / Street Address *City* *State* *Zip Code*

Home Phone Number: (_____) _____-_____ Mobile Phone Number: (_____) _____-_____

Work Phone Number: (_____) _____-_____

Email Address:_____@_____ .com / net

Primary Insurance: _____
Subscriber Name: _____
Relationship to patient: _____
Policy Number: _____
Group Number: _____

Secondary Insurance: _____
Subscriber Name: _____
Relationship to patient: _____
Policy Number: _____
Group Number: _____

If this is Workers Compensation Injury, please complete the following information:

Insurance Company: _____ Claim Number: _____

Phone Number: _____

CONSENT TO VIDEOTAPE AND PHOTOGRAPH

I,_____, hereby give consent for Excel Physical Therapy of Naples, Inc. to take and/or display photograph(s) and/or videotape of my physical therapy treatment(which will include my face and body). The photograph and/or videotape will be used for educational and/or advertising purposes by Excel Physical Therapy of Naples, Inc. and may be displayed on their website at www.physicaltherapyofnaples.com, Facebook, Google and/or YouTube. Excel Physical Therapy of Naples, Inc. will protect my personal data (full name, age and date of birth) from being displayed. I hereby confirm that I give consent for the **material** set out on the attached request form to be published. I confirm that the purpose for which the material may be used has been explained to me in terms which I have understood. It has been made clear to me that refusal to consent will in no way affect my physical therapy treatment.

In case of emergency please notify:

Name: _____ Relationship to patient: _____

Phone Number: (_____) _____-_____

_____ _____/_____/_____
Signature *Date*

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MEDICAL HISTORY

Name:_____ **DOB:**_____ **Date:**_____

Occupation, including activities that comprise your workday:_____

Age: **Height:** **Weight:**

Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**

Do you smoke? Yes No **Do you have a pacemaker? Yes No**

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue
❑ numbness or tingling
❑ fainting
❑ muscle weakness
❑ difficulty maintaining balance while walking
❑ weight loss/gain
❑ dizziness/lightheadedness
❑ falls

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑cancer
❑heart problems
❑chest pain/angina
❑ high blood pressure
❑ circulation problems
❑ lung problems
❑anemia
❑ other arthritic condition
❑stroke
❑diabetes
❑osteoporosis
❑ multiple sclerosis

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Current medications:

Medication (all prescriptions, over-the counters, herbals and vitamin/mineral/dietary (nutritional) supplements)	Dosage	Frequency	Route(oral, sublingual, subcutaneous injections, and/or topical)

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

What date (roughly) did your present symptoms start? _____

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What do you think caused your symptoms? _____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

I should not do physical activities that might make my pain worse: ❑ Disagree ❑ Unsure ❑ Agree

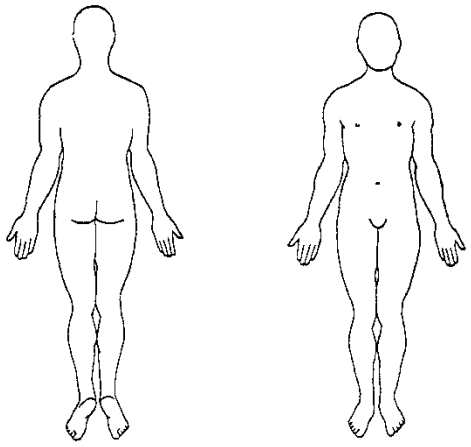
Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ❑ Yes ❑ No When_____ Treatment rec'd_____

Body Chart:

Please mark the areas where you:
Feel symptoms on the chart to the right with:
The following symbols to describe your symptoms:



↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**

My symptoms currently:❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1. _____
2. _____
3. _____

When are your symptoms worst? ❑Morning❑Afternoon❑Evening❑Night❑After exercise

When are your symptoms better? ❑Morning❑Afternoon❑Evening❑Night❑After exercise

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Using the 0 to 10 scale, with 0 being *"no pain"* and 10 being the *"worst pain"* pleased escribe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours:_____

The worst your pain has been during the past 24 hours:_____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Excel Physical Therapy of Naples, Inc. originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professional who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or health care operations

I understand that Excel Physical Therapy of Naples, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Excel Physical Therapy of Naples Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Excel Physical Therapy of Naples, Inc. change their notice, they will send copy of any revised notice to the address I've provided, (whether U.S mail or if I agree email).

I wish to have the following restrictions to use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____ _____/_____/_____

Patient Signature *Date*

Insurance – Financial Responsibility – Authorization to Release Confidential Information – Consent of treatment

1. I give consent for physical therapy evaluation & treatment to be administered by Excel Physical Therapy of Naples, Inc.

2. I authorize my medical records to be released to my referring physician and insurance carrier.

3. *WORKMAN'S COMPENSATION ONLY*: I authorize the release of my medical records to claim adjusters, case managers, and employers.

4. I agree to take responsibility for payment of services rendered that are deemed patient responsibility by my insurance plan or deemed by self-pay costs. My treatment will be billed to my insurance company if I have chosen this option, and I will be responsible for my deductible, copayments, and co-insurance costs. I will be charge the usual and customary charged based on the fee schedule for rehabilitation that my insurance carrier has developed or allowed. **If my insurance carrier denies payment for my services due to my own insurance eligibility and benefits or refuses to provide payment within 45 days after the claim was submitted, I will be fully accountable for payment to Excel Physical Therapy of Naples, Inc.**

5. I authorize my insurance carrier to directly pay Excel Physical Therapy of Naples, Inc. for my service appropriately rendered and billed for.

6. I recognize that it is my responsibility to remit checks issued directly to me from my insurance carrier to Excel Physical Therapy of Naples, Inc. if my insurance carrier issues payment to me for services rendered and I have a remaining balance with Excel Physical Therapy of Naples, Inc.

I agree, in order for Excel Physical Therapy of Naples, Inc. to service its account or to collect any amounts owes, Excel may contact me at any telephone number associated with your account. We may also contact you by sending text messages or e-mails if provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree to the terms.

_____ _____/_____/_____

Patient Signature *Date*

EXCEL
Physical Therapy of Naples

Cancellation / No Show Policy

This policy has been established in order to provide the highest level of Physical Therapy Service to all of our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of a cancellation we may be able to accommodate other patients with your appointment slot.

If you are unable to keep a scheduled appointment, please give 24 hours advance notice. If you do not cancel your appointment within 24 hours notice you will be charged seventy five dollars **($75)** cancellation/no show fee. This fee is not covered by your health insurance. We do understand that emergencies arise and that it may not be possible to give such a notice. Exceptions will be made to the appropriate cancellation/no show reason.

Payment Information:

Patient's Name: _____ Date of Birth: _____

Type of Credit card: ____ Visa ____MasterCard ____Discover ____American Express

Digit Credit Card Number: _____ _____ _____ _____

Expiration Date: ____/____ Security Code: _____ Zip code:_____

We ask that you please be courteous of your provider's valuable time and attention. The Physical therapists, office staff as well as your fellow patients will thank you.

Please be aware, cancelation or rescheduling of your appointments has to occur during business hours. Cancelling or rescheduling your apponitment after business hours will be considered late, and you will be charged the late cancellation fee.

*I consent that I will be charged seventy five dollars **($75)** cancellation/no show fee if I don't cancel or reschedule my appointment within 24 hours notice.*

_____ _____

Patient Signature Date

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