Physical Therapy & Sports Rehabilitation

Intake

Name _____ Preferred name: _____ Date of Birth: _____
Last First MI

Mailing Address _____
Street City State Zip Code

Home Phone w/ area code _____ Work Phone _____ Cell Phone _____

Contact Preferences: ☐ Home ☐ Work ☐ Cell E-mail Address _____

Social Security Number: _____ Sex: ☐ Female ☐ Male

Place of Employment: _____ or check if: ☐ Retired ☐ Self Employed

Referring Physician _____ Primary Care Physician _____

Please bill my:
☐ Primary Health Ins. ☐ MVA: Date of injury _____ ☐ Workers Comp: Date of Injury _____

Emergency Contact _____ Relationship _____

Home Phone w/ area code _____ Work Phone _____ Cell Phone _____

If a Patient is a minor
Responsible party for bill if other than patient: _____ Relationship: _____

Responsible party's address (if other than above) _____

Date of Birth _____ Social Security # _____ Phone # _____

Consent for Treatment:
I consent to treatment and authorize the use of this signature on insurance claims pertinent to physical therapy treatments received at Excel Physical Therapy. I understand that Excel PT and its staff cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that for my PT to be effective I must attend as prescribed and scheduled and comply with the home treatment program assigned to me. I understand that if I have difficulty with any part of my treatment program I am responsible for discussing it with my therapist. I hereby verify the information provided is accurate and up to date to the best of my knowledge.

Consent to Release:
I authorize Excel PT to release any information about my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____.

Consent to Obtain Medical Information:
I authorize Excel PT to obtain and acquire any information that would be beneficial about my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature _____ Date _____