Welcome to Xcel Physical Therapy

Ben and staff at Xcel apologize in advance for the amount of paperwork. We are trying to provide you the best treatment and in doing so, it is helpful to collect this information.

If you have a list of medications, surgeries, etc. that you want us to copy we would be happy to do so to expedite this process.

It is your responsibility and best interest to check with your insurance company regarding coverage of physical therapy services. We would be happy to assist with this process but cannot guarantee your benefits as described to us.

When checking in for service we expect copayment, deductible and/or co-insurance on the date of service. Use of credit cards will include a 3% processing fee.

351 S. Straits Hwy. • P.O. Box 829 • Indian River, MI 49749 Phone 231-238-2302 • Fax 231-238-2303

Xcel PHYSICAL THERAPY

"Work Better • Live Better • Play Better"

Consent for Treatment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Xcel Physical Therapy, including therapists who practice under the name, for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills, or conduct health care operations of Xcel Physical Therapy. I understand that assessment or treatment of me by the therapists of Xcel Physical Therapy may be conducted upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Xcel Physical Therapy is not required to agree to the restrictions that I may request. However, if Xcel Physical Therapy agrees to a restriction that I request, the restriction is binding on Xcel Physical Therapy and the therapist that practice therein.

I have the right to revoke this consent in writing at any time except to the extent that Xcel Physical Therapy or its therapists have taken action in reliance on this consent.

My protected health information means information including my demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Xcel Physical Therapy Notice of Privacy Practice prior to signing this document. Xcel Physical Therapy notice of privacy practice has been made available to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Xcel Physical Therapy. The Notice of Privacy Practices for Xcel Physical Therapy is also provided at the front desk. This Notice of Privacy Practice also describes my rights and the Xcel Physical Therapy duties with respect to my protected health information.

Xcel Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office or requesting by writing/mail, or asking for one at my next appointment.

Printed Name: _____
Signature: _____
Legal Guardian: _____
Date: _____

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Patient Registration Form

Name:_____ SS#: _____

Home Phone: _____ Other Phone: _____

Birth Date: ___/___/___ Age: ____

Home (Local) Address: _____City/Zip: _____

Secondary Address (address/city/state/zip): _____

Email (optional): _____

Primary Insurance: _____ Subscriber: self___ spouse ___ parent ____

Secondary Insurance: _____Subscriber: self___ spouse ___ parent ____

Friend/relative in case of emergency: _____ Phone: _____

Primary / Family Physician: _____

Case Manager (typically with auto or work injuries): _____

Case Manager Phone #: _____

Injured body part(s): _____

Circle all that apply: Pain Swells Catches restricts mobility gives out

Initial the following:

_____I consent to the evaluation and on going treatment of physical and/or occupational therapy services at Xcel Physical Therapy. I may decline any intervention at any time by verbalizing my wishes to my therapist.

_____I have had the opportunity to review the HIPAA Privacy and Disclosure Notice at Xcel Physical Therapy and agree to the release of information as stated in that notice.

_____I assign directly to Xcel Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Xcel Physical Therapy to release all information necessary to secure the payment of benefits, including but not limited to your (patient) insurance or third party payor. I authorize the use of this signature on all of my insurance submissions. I have no mental or cognitive issues that would preclude me from authorizing treatment, or accurately fill out the documentation, or understand my rights as a patient.

Parent/Legal Guardian/or person 18 years old or older must sign the following:

Signature: _____ Date: _____

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PHYSICAL THERAPY

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Intake Questionnaire

Name:_____

Employed_____Not working ____Disabled _____ Retired _____Student _____
Employer Name: _____ Employer Phone: _____
What is your occupation? _____

Marital Status: Married _____ Divorced_____ Widow _____ Single ____

Are you pregnant or is there a chance that you might be pregnant? _____Yes _____No
Have you fallen in the past year? _____Yes _____No

Date of injury/when condition began: _____
Prior to your injury did you have any limitations or restrictions: _____Yes _____No
If yes, did you use any equipment such as walking aides or reachers _____Yes _____No

Have you previously injured this body part? Yes____ No ____
If so when : _____

Is this a work related injury? Yes_____ No _____
If so did you lose time from work due to this injury? Yes____ No _____
If yes, have you returned to work? Yes _____ No_____
Please tell us how much lost time from work you suffered? _____weeks _____ months

Is this an auto related injury? Yes _____ No _____

Have you ever sought medical attention following a vehicle accident? Yes _____No _____

Using this scale rate your pain over the past 48 hours: (no pain) 0-1-2-3-4-5-6-7-8-9-10 (most severe pain)
At the Worst_____ Best _____ Now _____

What is your height? ___feet ____ inches; What is your weight? _____ pounds

Social History
Do you live: alone____ with spouse____ with family____
Are there any children or dependants that reside in your home? Yes (how many)____ No___
How many stairs to get into dwelling?: _____ How many stairs inside dwelling?: _____
Are there cultural/religious practices that we should respect during your therapy?
If so please explain:_____
Do you smoke? **No Yes** (packs per day_____)
Do you <u>regularly</u> consume alcoholic beverages? **No Yes** (amount per day_____)
Have you recently had any additional stress in your life? **No Yes**
If yes, please explain: _____

CONTINUED ON REVERSE SIDE >>>

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Intake Questionnaire (Page 2)

Which diagnostic tests have been performed on you for this condition?

_____MRI _____CT Scan _____X-ray _____ Bone Scan
_____EMG/NCV (nerve test) _____Lab/Blood Tests

Past Medical History (please check all that apply)

High Blood Pressure ___	Cancer ___	Low Back Pain ____
Heart Attack ___	Heart Disease ___	Neck Pain ____
Pacemaker ___	Osteoarthritis ___	Osteoporosis ____
Rheumatoid Arthritis ____	Seizures/Epilepsy ___	Blood Clot____
Diabetes ___	Asthma ___	Lung Condition/COPD ____
Polio ___	Headaches ___	Fainting/Dizziness ____
Fractures ____	High Cholesterol ___	Peripheral Vascular Disorders ___
Cardiac arrhythmia ____	Depression ___	Stroke ___
Migraines ____	Recent Infection ____	Kidney Stones ____
Anemia ____	Gout _____	Shingles _____

Other (please list): _____

_____

Surgeries (list all): _____

_____

Current Pain Medications (please check all that apply):

Advil/Motrin/Ibuprofen___	Vicodin____	Darvocet _____
Tylenol/Acetaminophen___	Flexeril/Skelaxin___	Oxycontin/Oxycodone___
Capsaicin ____	Hydrocodone____	Lidoderm/Lidocaine patch___
Lortab_____	Norco____	Morphine (MS Contin)_____
Gabapentin (Neurontin) ____	Pregabalin (Lyrica)___	Carbamazepine (Tegretol) ____
Duloxetine (Cymbalta) ____	Amitriptyline _____	Percocet ___
Ultracet ____	Ultram (Tramadol)___	Darvon ___
Duragesic (Fentanyl) patch___	Codeine ____	Hydromorphine (Dilaudid or Palladone) ___
Meperidine (Demerol) ___	Valium____	Mephobarbital (Mebaral) ____
Alprazolam (Xanax) ____	Cymbalta _____	Flexor Pain Patch _____
Chlordiazepoxide HCL (Librium) ____		Pentobarbitalsodium (Nembutal) ___
Naprosyn/Naproxyn/Aleve/Anaprox _____		Other: _____

Other Medications:

_____

_____

Please check any of the following symptoms you currently have or had around the time of your injury:

___History of steroid/corticosteroid use	___Excessive thirst
___Fever or night sweats	___Unexplained Sweat
___Loss of bowel or bladder control	___Unexplained fatigue
___Pain that awakens you at night	___Pain/difficulty with urination or discharge
___New or unexplained skin rashes or jaundice	___Blood in urine or change in color of stools
___Recent unexplainable loss of weight	___Nausea or vomiting

___Pain that increases or worsens with lying down

___Dizziness or shortness of breath with usual activities