Xcel Rehab

Patient Information

Historical Data:

Name: _____ Date: _____
First MI Last

Sex: Male Female Marital Status: Married Single Divorced

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home_____ Cell_____

Email Address: _____

Date of Birth: _____ SSN: _____

Employer: _____Work Phone: _____

Insurance:
Name of Primary Insurance: _____

Insured's Name: _____Relationship to you: _____

Policy Number: _____Group Number: _____

Date of Birth of Insured: _____SSN of Insured: _____

Name of Secondary Insurance: _____

Insured's Name: _____Relationship to you: _____

Policy Number: _____Group Number: _____

Date of Birth of Insured: _____SSN of Insured: _____

Referring Physician: _____

Referring Physician Phone: _____

Emergency Contact: _____Phone: _____

Relationship to you: _____

How did you find out about our clinic? _____

_____

Designated People that your health information may be discussed with:

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Patient/Guardian Signature: _____Date: _____

Patient Medical Information

Is your injury due to a Motor Vehicle Accident? _____

Did you sustain your injury while on the job? _____

Is this a workers comp case? _____

If you answered yes to any of the 3 previous questions, please fill in the following information:

Date of Injury/Accident: _____ Contact Person: _____

Phone: _____ Fax: _____

General Health: Excellent Good Fair Poor
(Circle one)

Do you exercise? _____If so, how often? _____

Medical Conditions: _____

_____

Medications: _____

Allergies (Y) or (N) If yes, What type: _____

Past Medical History: _____

_____

Past Surgical History: _____

_____

Current Condition(s)/Symptoms requiring PT: _____

_____

Describe your pain in the last couple of days: No Pain Mild Moderate Severe
(Circle one)

Shade in the circle that correlates with the maximum level of pain with activity:

0 1 2 3 4 5 6 7 8 9 10

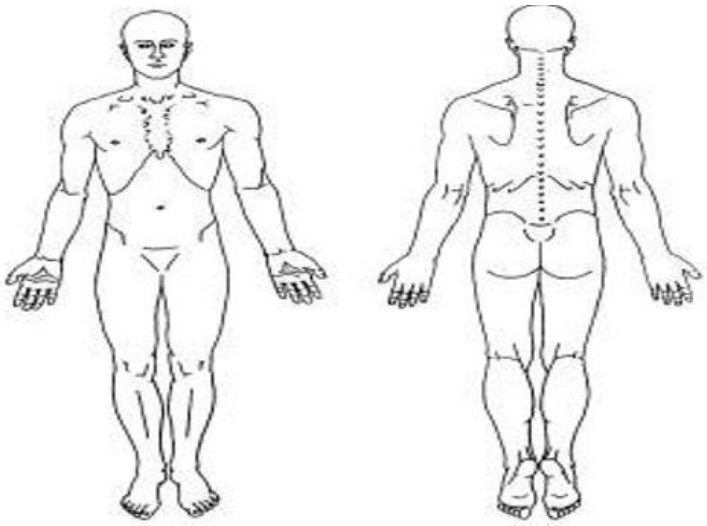
Shade in the circle that correlates with the maximum level of pain at rest:

0 1 2 3 4 5 6 7 8 9 10

Shade in the circle that correlates with the maximum level of pain in the past week:

0 1 2 3 4 5 6 7 8 9 10

Please place an "X" where your pain is located on the drawing below.



Where is your pain located? _____

How would you describe the pain? Dull Achy Sharp Numb Tingling
(Circle all that apply)

When did your symptoms start? _____

What makes your symptoms worse? _____

What eases your symptoms? _____

Have you received other treatment for your current condition? Yes _____ No _____

If yes, what type of treatment? _____Was it helpful? _____

Have you ever received Myofascial Release? Yes __ No __ If Yes, where: _____

What are your goals/expectations for Physical Therapy? _____

_____

Patient/Guardian Signature: _____Date: _____

Xcel Rehab
Patient Policies

Patients
For new and returning patients, please bring your valid prescription, driver's license, insurance card, plus all patient intake forms listed on our website at www.xcelrehab.com. This information can be also be faxed to the location desired prior to your appointment. If you do not have the patient intake forms filled out prior to your initial visit, please arrive 15 minutes early so that they can be completed before your scheduled appointment. **If you do not have a PT prescription with you at the time of your initial appointment, we will not be able to treat you.**

PT Prescription/Physician Referral
If you do not have a prescription for Physical Therapy, we ask that you call your primary care provider's office to request one be sent to us at our fax number. It should read, "Physical Therapy to evaluate and treat" and include a frequency and duration as specified by your primary care provider. After evaluation, we will fax your Physical Therapy plan of care to the primary care provider you identified, for a signature, to indicate that he/she approves of the established plan of care set by the evaluating Physical Therapist. A valid prescription can be obtained by a licensed physician, nurse practitioner, chiropractor or dentist.

Pearl Fax Number: 601-510-9500
Madison Fax Number: 769-257-6382

Fees/Payment
Deductibles, Copayments and/or Coinsurances, based on your insurance policy, is due at the time each session is rendered. We accept cash, credit cards and checks.

Treatment Sessions
A session typically lasts for 1 hour. For your evaluation and each visit thereafter, please wear or bring clothes that are appropriate for exercise and that allow us to treat at and around the affected area (such as shorts or sweat pants and a t-shirt or tank top). Patients receiving Myofascial Release will be provided a gown so that the affected area can be treated effectively and appropriately, however, a patient's attire will be based on the patient's comfort level and choice.

Tardiness
We ask that you arrive 5 minutes early for your appointments and that you are considerate of the next patient's time when your session ends. If you arrive late, your treatment time may be shortened to accommodate scheduling of other patients.

Cancellations/No Shows
Please give us 24 hours-notice if you are unable to keep your appointment. Failure to give **24 hours-notice**, will give Xcel Rehab, Inc. the right to charge half of the amount of the expected services to your credit card at their discretion. When calling to cancel the same day of your appointment, if you will reschedule for another date that week, a fee will not be charged to you. **No-shows will result in a $40.00 charge** (Uncontrollable circumstances will be reviewed on a per-case basis).

Consent to Treat

The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures as requested by the Physician prescribing care. Your Physical Therapist will monitor your progress and adjust the treatment frequency and duration according to medical necessity as needed.

Medical Information/Medical Records

We have given you our HIPAA Privacy Policy which is a notice of our legal duties and privacy practices with respect to medical information about you. Please make sure you have completed all intake forms fully to ensure that your medical record is complete.

Signature of Patient or Guardian: _____
(Please have the Guardian/Caregiver sign if patient is under 18)

Printed Name: _____

Date: _____

Xcel Rehab

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to make available to you a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information. If you would like a copy of these Privacy Practices, please come up to the desk and ask our Receptionist for a copy.

By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices is available to me upon request. I understand that a copy of this consent form may be used with the same effectiveness as the original.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign
- Due to an emergency, it was not possible to obtain an acknowledgement
- We weren't able to communicate with the patient
- Other (please provide specific details)