EXCEL PHYSICAL THERAPY & REHAB

3323 Shattuck Road, Suite # 2
Saginaw, MI 48603
Tel: (989) 341-1919
Fax: (989) 341-1920
www.excelptmi.com

Medical History and Intake Sheet

Please report your current complaints for which you are seeking the treatment: ___________________
____

Please describe briefly how the current symptoms started: _____________________________________
____
____

Please describe your current functional limitations due to your medical condition:

☐ Sitting ___________ mins.	☐ Standing ___________ mins.	☐ Walking ___________ mins.
☐ Stair Climbing	☐ Sleeping ___________ / night	☐ Lifting ___________ pounds
☐ Laundry	☐ Vacuuming	☐ Driving ___________ hours
☐ Dressing/undressing	☐ Yard Work	☐ Other: _______________

☐ Employment, please describe: ____

Please describe any other treatments sought till date: ____

Please describe any testing (X-ray, MRI) completed till date: ____

Are you allergic to latex: Yes/No **Follow up appt. with your physician:** ____________

Dominant side: R/L **Prior Physical Therapy: Yes/No**

If female, are you pregnant: Yes/No/Maybe **Do you smoke? Yes/No**

Body Diagram and Pain Scale

Instructions: On the body diagram shown on the side, mark the areas of pain or other symptoms according to symbol key below presently experiencing.

Symbol Key: Pain: →→→→ Numbness: ===== Tingling: ×××× Burning: ++++

Pain Scale Instructions: On the line below, please mark the intensity of pain presently experiencing.

PAIN SCALE

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate pain Severe pain

Last Name: DOB:

First Name: Chart#: EPT-

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Patient's Goal

Your goal from therapy: ____
____

Medical History

Please check any medical condition for which you are being treated currently or in past.

- ☐ Diabetes Mellitus
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Accident
- ☐ Respiratory illness
- ☐ Head injury
- ☐ Carpal Tunnel
- ☐ Heart Problems
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Blood clot/disorders
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Epilepsy/Seizures
- ☐ Multiple Sclerosis
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Gout
- ☐ Dizziness
- ☐ Broken bones/Fractures
- ☐ Other:

In the past year, have you experienced any of the following?

- ☐ Difficulty sleeping
- ☐ Loss of appetite
- ☐ Depression
- ☐ Loss of balance
- ☐ Unexplained changes in weight
- ☐ Vision/hearing changes
- ☐ Unexplained weakness
- ☐ Bladder/bowel problems
- ☐ Difficulty breathing/chest pain

Please list all current medications including those over the counter: ______________________
____
____

Surgical History

Please list any surgeries and an approximate year of Surgery	Year
______________________	__________
______________________	__________
______________________	__________
______________________	__________
______________________	__________

STOP!!! OFFICE USE ONLY

****

Height: __________ inches Weight: ________ lbs. Pulse: ________ bpm Arm: R/L Rad/Car

BP: ______/_______ mm of Hg Arm: R/L. Position: Sit/stand/lying Init. ______

Last Name: DOB:

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Financial Policy and Consent to Care

Payment Policy

Your contract for health insurance is between you and your insurance company. We are not a party to that contract. Physical therapy services that you receive and the bill is an agreement between you and Excel Physical Therapy& Rehab, PLLC. Agreements with insurance companies vary greatly and it is your responsibility to know what your insurance covers and what portion you are responsible for. Our office staff will be happy to assist you in obtaining this information and will gladly bill your insurance company directly on a weekly basis. **However, your physical therapy bill including all co-pays and deductible is ultimately your responsibility and any out of pocket costs are expected to be paid at the time of visit. While we accept all forms of payments, payments made by a credit card will be subject to 3.5% surcharge that is not greater than our cost of acceptance. Debit card and other form of payments do not have additional surcharge.** An itemized statement of physical therapy services and insurance reimbursement along with any balance will be sent to you periodically. It is your responsibility to pay the balance within 30 days of receiving such statement. Any account over 30 days old will be assessed a late fee of $25.00. Any account over 60 days old will be considered delinquent and will be turned over to a collection agency resulting in additional administrative charges of up to $25.00 and will affect your credit rating. There are payment plans available that can be set up by contacting our billing manager**. ________ Int.**

Optional Paperless Billing

I also consent my billing statements to be emailed at ____
I understand by choosing this option, I will not be mailed a physical statement. ______________ **Int.**

Authorization for Release of Information

I hereby authorize the release of information of any medical records for the purpose of financial reimbursement to Excel Physical Therapy & Rehab. I request that payment be made directly to Excel Physical Therapy & Rehab for the services rendered. I consent to the release of any medical records to be reviewed by authorization representation of Medicare, Medicaid, Blue Cross Blue Shield/Blue Shield of Michigan, and/or my private insurance carrier.

Consent for Care

I hereby consent and authorize Excel Physical Therapy & Rehab to provide care and carry out all procedures as prescribed by my physician in the plan of care established. A representative of this organization has explained my plan of care and answered all of my questions satisfactorily.

Absentee Policy

Due to the large volume of patients seen at this practice, it is the patient's responsibility to arrive on time for their scheduled appointments. Patient who is more than 15 minutes late without a valid reason will be rescheduled. **Cancelled appointments with less than 24-hour notice without a bonafide reason will result a charge of $50.00 that is patient's responsibility and not covered by insurance. Patients who "failed to show" for 2 or more appointments will also be assessed $50.00 no show fee per appointment and discharged without further notification.**
I have read the Financial Policy. I understand and agree to this Financial Policy.

Sign: ____________________________________ Date: _____________
Patient or legal representative

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Privacy Policy of Excel Physical Therapy and Rehab, PLLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY
Excel Physical Therapy & Rehab is committed to maintaining and protecting the confidentiality of your protected health information (PHI). We are required by federal and state law to protect the privacy of your PHI.

USES AND DISCLOSURES
Treatment: Your PHI may be shared with staff members and referring physician for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.
Payment: Your PHI may be used to seek payment from your health insurance or from other sources of coverage such an automobile insurer, or worker's compensation carrier. This includes third parties such as billing agencies.
Health Care Operation: Your PHI may be used as necessary to support the day-to-day practice and management of Excel Physical Therapy & Rehab that may include but not limited to quality improvement, budgeting, and financial reporting.
Law Enforcement: Your PHI may be disclosed to law enforcement agencies, without your permission to support facilitate law-enforcement investigations, government audits and inspections, and to comply with government mandated reporting.
Lawsuits and Disputes: Your PHI may be disclosed in response to a court or administrative order or dispute and Excel Physical Therapy & Rehab is served with a subpoena, warrant, summons, or other lawful process.
Public Health Reporting: Your PHI may be disclosed to public health agencies as required by law to report certain communicable diseases to the state Public Health Department.
Appointment Reminders: You may be contacted by our staff regarding appointment openings and reminders. If you have any concerns about us leaving messages or information pertaining to appointment dates and times with other household members, please let us know. No confidential patient information will be left by phone.
Other uses and Disclosures Require Your Authorization: Disclosure of your PHI or its use for any purpose other than those listed above requires your specific authorization. If you change your mind after authorizing a use or disclosure of your information you may submit in written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred prior to such notification.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:
- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

RIGHTS TO REVISE PRIVACY PRACTICES
As permitted by law, we reserve the right to amend or modify our privacy policies and practices in accordance with federal and state laws. You will be provided a revised notice should such a change occurs.

REQUEST TO INSPECT PHI
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing to our office.

I ACKNOWLEDGE that I have received a copy of Excel Physical Therapy & Rehab's notice of privacy practices. I understand that this information describes how Excel Physical Therapy & Rehab may disclose and use my PHI.

Patient's Name: ____ (please print)

Patient's Signature: ____ Date: ______________________