Excel Physical Therapy
"A Passion for Caring, a Reputation for Results"

Excel Physical Therapy
3140 West Ward Road Suite 203
Dunkirk, MD 207543027
Phone: ***410-286-7205***
Fax: ***833-268-8390***

Patient Information Sheet

Please verify your demographic information as entered below. If any information is incorrect or missing, make corrections on this page and return to the front desk to have your patient record updated.

Patient Demographic Information:

Name:_____

Date of Birth:_____/_____/_____

Emergency Contact Name: _____

Emergency Contact Phone #_____ Relationship _____

Injury result of Accident? Y NAccident Date _____ State accident occurred _____

Claim Type (circle one): Workers Compensation Auto Accident Does Not Apply

How did you hear about us? ☐ Return Patient☐ Friend/Family ☐Doctor☐ Other:_____

Appointment Reminders:

We provide appointment reminders as a courtesy. You are responsible for remembering your scheduled appointment day and time. Please indicate which number and how you would like to receive appointment reminders.

Check One below Check One below

I would like reminders via: ☐ TEXT☐ VOICE CALL Send reminders to my ☐ Cell Phone☐ Home Phone

Appointment reminders are sent from an automated system. To change or cancel an appointment you must call the office directly at 410-286-7205. Changes/cancellations cannot be made via text.

For all other communication please call my:☐ Cell Phone☐ Home Phone ☐ Other: _____

It is okay to leave a general message at this number(s) ☐ Yes ☐ NO

Please complete the attached release if you wish to have information released to a third party. (e.g. Spouse, Attorney)

CANCELLATION/NO SHOW Appointments must be canceled at least 24 hours prior to your scheduled appointment. **If you do not show or fail to attend your appointment without proper notice this is considered a "Short Cancel" and will be charged a Cancellation Fee of $50. If you fail to show up for your scheduled appointment, this is considered a "No Show" and you will be charged a No Show Fee of $70.**

Early/Late Arrival – Patients are seen in the order of their scheduled appointment times, not the time of their arrival. If you arrive early or late for your appointment, we will do our best to accommodate you. **Should you arrive late to your appointment, we will do our best to accommodate you but we may have to shorten the appointment in order to not disrupt treatment to other patients.**

Financial Policy

The following is a statement of our Financial Policy. Please read these statements carefully and ask any questions prior to signing below.

Your insurance is a contract between you and your insurance company. We are not a party to that contract. The benefits quoted are those provided by your insurance company or their representative. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Chiropractors and other medical providers may bill "physical therapy codes" to your insurance reducing the number of visits available.

Assignment of Benefits: I hereby authorize and direct any insurance company to pay the proceeds of any benefits due to me for services rendered by Excel Physical Therapy directly to the provider.

Copays, Coinsurance, Deductibles: It is our policy to collect copays at the time of service. Coinsurance is an estimated amount; we will not know the exact amount until the claims are processed. The estimate is based on the *average* patient's responsibility. If you have a deductible that has not been satisfied the amount you will be asked to pay will be based on the *average* patient's responsibility. The difference between the amount you have paid and the amount not covered by insurance is the patient's responsibility. Please inquire if you would like to discuss payment arrangements.

Returned Checks: If your check is returned to us by your bank unpaid for any reason you will be charged a $50.00 fee in addition to the amount of the check.

No Show: If you fail to show for your scheduled appointment, you will be charged a No Show Fee of $70. This fee cannot be billed to your insurance company; therefore, the fee is the patient's responsibility and is due prior to your next therapy appointment.

Cancellation Policy: **Appointments must be canceled at least 24 hours prior to your scheduled appointment**. If you fail to attend your appointment without proper notice, this is considered a "Short Cancel". **The fee for a short cancellation is $50**. This fee cannot be billed to your insurance company; therefore, the fee is the patient's responsibility and is due prior to your next therapy appointment. If you have to cancel on the weekend or after hours, please call our office at 410-286-7205 and leave a message.

Responsibility Agreement: I acknowledge and understand that I am responsible for all the charges for all services rendered to me or a member of my family. Although I have requested that my bill be submitted to my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable amount of time. If for any reason a portion of my bill is not paid by my insurance company, I further agree to make arrangements for payment of the bill. Excel Physical Therapy will initiate authorization and verify insurance benefits as a courtesy to me; however, this is not a guarantee of payment and does not waive my responsibility for payment for services unpaid by my insurer. I will provide Excel Physical Therapy with any changes in address, employment or insurance within ten (10) days of any changes.

By signing this agreement below, I acknowledge that I have read and understand the financial policy.

_____

Printed Name Signature & Date

Knowledge and Release of Information: I authorize Excel Physical Therapy to release to my referring physician and insurance company any information including my diagnosis and records of treatment, concerning my medical history and therapy. I authorize Excel Physical Therapy to file an appeal or grievance on my behalf to contest any adverse decisions by an insurer. I agree to sign an authorization for this purpose, if necessary. Excel Physical Therapy and involved provided are released from liability arising from reliance on this authorization to release Protected Health Information.

Release of Information to Third Parties

Your insurance company and referring physician will receive appropriate billing information and/or treatment notes. If you would like another person to be able to inquire about your case and/or treatment please choose one of the following:

☐ **I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:**

Name:
_____ Relationship: _____
Name:
_____ Relationship: _____

☐ **I do not want my information to be released to anyone.**

This release of information will remain in effect until terminated in writing.

Notice of Privacy Practices

I have been offered a copy of Excel Physical Therapy's Notice of Privacy Practices. I have been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange my medical care, to seek and receive payment for services given to me, and for the business operations for the medical center, its staff and its business associates.

_____ _____ _____
Signature of Patient or Parent/Guardian Date Relationship to Patient

_____
Printed Name of Parent/Guardian