1031 W.Williams St. Suite 103 Apex NC 27502 P:919.249.4040 F:919.249.4043

eXcel PHYSICAL THERAPY

Patient Information

Patient Name: _____Date Of Birth:_____
If minor, name of parent/guardian: _____
Address: _____City:_____Zip:_____
Phone:_____Email:_____
Emergency Contact:_____Phone:_____Relationship:_____

Primary Insurance

Name of Policy Holder_____Date Of Birth:_____

Secondary Insurance

Name of Policy Holder_____Date Of Birth:_____

Medical History

Heart Disease
Pacemaker
Seizures
Asthma

Allergies

Latex
Lotions
Other:
_____

Is this related to an Auto Accident

If Yes Date of Accident:_____

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

Consent to Release Information

I authorize Excel Physical , Inc permission to discuss my account with the following individual.

Name:_____Relationship:_____Date:_____

Assignment of Benefits

I assign all benefits to Excel Physical Therapy, Inc. I authorize release of records to any agency involved in the payment of treatment for the patient named below. I understand in the event that collection is necessary, I am responsible for all collection and attorney fees accrued on my account

No Show Cancellation Policy

There will be a $25 fee charged to your account for any no shows or for appointments not cancelled at least 24 hours prior to the appointment

_____	_____	_____
Printed Name of Patient or parent/guardian	**Signature of Patient or parent/guardian**	**Date**