Patient Intake Form

Welcome to Xcel Physical Therapy & Wellness Center, PC

Important: This form contains four main sections: (1) Patient Information, (2) Injury & Medical History, (3) Consent for Treatment, and (4) Payment Agreement. Please complete all sections carefully.

SECTION 1: PATIENT INFORMATION

First Name

Middle Name

Last Name

Suffix

Preferred Name

Email Address

Date of Birth

Patient Initials

CONTACT INFORMATION

Address

City

State

ZIP Code

Home Phone

Mobile Phone

Work Phone

INSURANCE INFORMATION

Home Health Care Declaration

☐ I attest that I am not currently receiving Home Health Care for any reason (i.e. Medicare Part A)

Primary Insurance

Company Name

Subscriber ID

Secondary Insurance

Company Name

Subscriber ID

FINANCIALLY RESPONSIBLE PERSON

Financially Responsible Person

Full Name

Date of Birth

Relationship to Patient

PHYSICIAN REFERRAL

Physician Name

Physician Phone

Physician Referral

EMERGENCY CONTACT

Contact Name

Phone Number

Relationship

SECTION 2: INJURY INFORMATION & MEDICAL HISTORY

Date of Injury

Did you have surgery?

☐ Yes ☐ No

Date of Surgery

Surgical Procedure

Were you in a car accident?

☐ Yes ☐ No

Date of Accident

Were you injured at work?

☐ Yes ☐ No

Is litigation involved?

☐ Yes ☐ No

What is the name and phone number of your attorney?

Have you had physical therapy for this condition before?

☐ Yes ☐ No

If yes, did it help?

Please describe the injury

SYMPTOMS & THERAPY GOALS

What activities/movements cause your symptoms?

What activities are most affected by your symptoms?

What would you like to achieve through physical therapy care?

PAST & CURRENT MEDICAL HISTORY

Check all conditions that apply to you

Column 1	Column 2	Column 3
☐ Allergies	☐ Emphysema	☐ Pacemaker
☐ Anemia	☐ Fibromyalgia	☐ Parkinsons
☐ Anxiety	☐ Fractures	☐ Pulmonary Disease
☐ Arthritis	☐ Gallbladder Problems	☐ Rheumatoid Arthritis
☐ Asthma	☐ Heart Disease	☐ Seizures
☐ Cancer	☐ Hepatitis	☐ Smoking
☐ Chemical Dependency	☐ High Blood Pressure	☐ Speech Problems
☐ Currently Pregnant	☐ Incontinence	☐ Stroke
☐ Circulation Problems	☐ Kidney Problems	☐ Thyroid Disease
☐ Depression	☐ Metal Implants	☐ Tuberculosis
☐ Diabetes	☐ Multiple Sclerosis	☐ Vision Problems
☐ Dizzy Spells	☐ Osteoporosis	

Do you have any other medical conditions or diagnoses of which we should be aware? If yes, please describe.

Have you ever had surgery? If so, describe the procedure below, including the month and year of the operation.

Describe your recreational activities.

PATIENT AUTHORIZATION

Patient Name (Please Print)

Date

Patient Signature (or authorized agent)

MEDICATIONS & PAIN ASSESSMENT

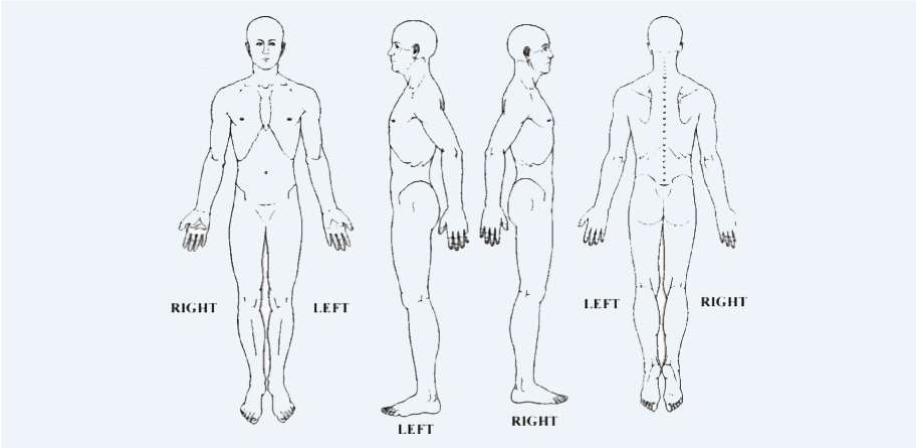
Please list all medications you are currently taking

Pain Locator Instructions

Using the body diagram below, please mark the areas where you feel the described sensation. Use the following symbols:

NNN - Numbness
BBB - Burning
TTT - Tingling or Pins and Needles
XXX - Stabbing or Aching Pains

Pain Scale (0-10): Please rate your average pain level where 0 = no pain and 10 = most severe pain imaginable. Mark your level next to each affected body part.



Note: Patient must sign and date this page in his or her own handwriting. Thank you.

SECTION 3: CONSENT FOR TREATMENT AND INFORMATION USE

I have read and fully understand XCEL PHYSICAL THERAPY & WELLNESS CENTER, P.C.'s (XPT&WC) "Notice of Privacy Practices." I acknowledge that the Health Insurance Portability Act (HIPAA) Notice of Privacy has been made available to me. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that (XPT&WC) will consider requests for restrictions on a case-by-case basis but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in (XPT&WC) "Notice of Privacy Practices." I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

UNDERSTANDING "ORTHOPEDIC MANUAL PHYSICAL THERAPY"

The licensed clinical staff at (XPT&WC) is trained in "manual therapy" techniques that are considered part of "orthopedic manual physical therapy." These and other traditional therapy activities, including electrical and hot/cold modalities and exercises will be implemented during your therapy. Use of "manual therapy" techniques implies physical contact is likely to occur between the therapist's hands and the body of the patient. In some cases, the techniques require close contact to safely perform the technique(s) correctly. We recognize this may be your first experience with physical therapy and the process may initially be unfamiliar. We will do our very best to explain the technique(s) to you. Please notify your therapist if you have questions about a particular technique, as we may be able to adjust the technique or change to a different technique to accomplish the desired intent.

"OPEN" ENVIRONMENT TREATMENT SETTING CONSENT

At (XPT&WC) we understand your privacy is important. We take necessary and reasonable action to protect your rights and Protected Health Information (PHI). Your experience, however, may differ from previous physical therapy and doctor's office experiences. For your protection and that of the therapists, our clinic is set up to treat patients in an "open" environment where incidental exposure of PHI may occur from time-to-time. Our extensive experience treating patients in this exact environment suggests it is a supportive setting fostering interaction and shared experience(s) with other patients. These experiences often set a positive tone facilitating recovery and ultimately improving the quality of your care.

Furthermore, this setting allows your therapist to interact with and monitor you and your progress at all times. We realize however some patients may not be entirely comfortable with this setting. If you require or prefer a private room for your exam and/or follow-up treatment, we encourage you to discuss your request with your therapist prior to your examination and we will do everything reasonably possible to accommodate your needs. Your treatment and our conduct toward you will be equivalent, regardless of the choice you make on this matter.

If you feel the management of your request has been inappropriate, please discuss your experience with the clinical director by calling Carrie Burgert at (805) 552-1915.

I have carefully read the above statement and understand that incidental PHI may be exposed to other patients being treated in the clinic simultaneously. I also understand that I retain the right to request a private room by notifying the therapist or receptionist before the initial exam or follow up treatment.

HIPAA COMMUNICATION CONSENT

- HIPAA stands for the Health Insurance Portability and Accountability Act.
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers is encrypted.

EMAIL

- Most popular email services do not utilize encrypted email.
- When we send you an email, or you send us an email, the information is not encrypted.
- The federal government provided guidance on email and HIPAA.
- https://www.hhs.gov/hipaa/index.html

TEXT

- Text messages are not encrypted.
- We use text strictly for scheduling purposes.

Email (Mark One)

☐ Allow unencrypted email

☐ Do not allow unencrypted email

Text (Mark One)

☐ Allow unencrypted text

☐ Do not allow unencrypted text

Email Address

Mobile Phone

I understand the risks of unencrypted email and text and do hereby give permission to Xcel Physical Therapy & Wellness Center, PC to send me personal health information via unencrypted email and/or text as indicated above.

SECTION 4: PATIENT CONSENT & PAYMENT AGREEMENT FOR SERVICES RENDERED

This is a contract entered into on the date indicated below between Xcel Physical Therapy & Wellness Center, PC ("Provider") and the undersigned Patient.

Agreement Date

Patient Full Name

A. Patient / Provider Relationship

Patient understands that it is Patient's full responsibility to have obtained any and all necessary referrals and authorizations required prior to treatment by XPT&WC. If Patient's insurance company requires a referral and Patient does not have one, then Patient understands and acknowledges that Patient will be responsible for the entire bill for rendered services. As such, Patient represents that the Patient has presented a physician's order, prescription, and/or a written referral, if applicable, to engage Provider to perform physical therapy services, including but not limited to: an Initial Evaluation of the Patient's injuries and therapeutic modalities including but not limited to joint manipulation, guided therapeutic exercises, guided functional exercises, neuromuscular re-education, therapeutic activities, gait training, A therapy, ice, heat, electrical stimulation, ultrasound, biofeedback and/or taping. Additionally, re-evaluations may be performed to assess the Patient's progress working towards desired outcomes due to a change in medical status. Patient acknowledges that No promises or guarantees have been made as to the results or outcomes of these treatments or modalities. XPT&WC hereby agrees to provide the Patient with such services in exchange for full payment of all financial consideration as described herein.

B. Benefit Coverage

A quote of benefits from your insurance carrier is NOT a guarantee of coverage. Therefore, XPT&WC is NOT responsible for inaccurate information provided by, to, or through your insurance company. WE HIGHLY RECOMMEND CALLING YOUR INSURANCE COMPANY AND VERIFYING YOUR COVERAGE, as it is solely your responsibility to call your carrier to determine and confirm your coverage ("Benefits") and confirm that XPT&WC is a participating provider under Patient's Coverage

For clarification, your insurance plan ("Coverage") is a contract between you and your carrier, not XPT&WC. Therefore, Patient understands that per Patient's insurance policy and the terms of this Agreement that Patient's Coverage may not cover 100% of Patient's bills for services provided, and as such, Patient acknowledges that Patient is financially responsible for any and all charges not covered by Patient's insurance, including any charges resulting from a misquote of Benefits or misunderstanding of Coverage

If Patient fails to provide all necessary and current insurance information, Patient understands that Patient's insurance company(ies) may deny payment of claims relating to services rendered to Patient by XPT&WC. As such, Patient fully understands and accepts that if such denial occurs, Patient will still be fully responsible for any and all outstanding balances with XPT&WC.

If the Patient is a minor, the parent/guardian hereby accepts all financial responsibility for all charges and/or fees not covered by insurance as previously stated.

Based on the information provided to us from your carrier, the estimated cost per treatment includes, but is not limited to co- pays and coinsurance, cost of services rendered, supplies and equipment, and are due, in full at time of service as shown and initialed by responsible party:

Estimated Cost - First Visit

Estimated Cost - Each Subsequent Visit

Patient Initials

BY INITIALING THIS SECTION, YOU ACKNOWLEDGE THIS INFORMATION IS AN ESTIMATE OF BENEFITS AND NOT A GUARANTEE OF PAYMENT. YOU ARE RESPONSIBLE FOR ALL TREATMENT RELATED FEES BASED ON YOUR CONTRACTUAL AGREEMENT WITH YOUR INSURANCE COMPANY EVEN IF THE EVENT YOUR BENEFITS WERE MISQUOTED TO US.

C. Payment for Services

Patient shall be fully responsible for all payments of services, including but not limited to deductible, co-insurance, co-payments, equipment, supplies, and charges not paid for, whether in part or as a whole, by insurance per Patient's insurance benefits. Patient's total unpaid balance for all services, deductible, co-insurance, co- pay amounts, and any unpaid equipment and supply charges (not paid at the time of issue) are subject to XPT&WC's collection policy.

XPT&WC's Collection policy is: All insurance claims responsible must be paid in full within Sixty (60) days following the date your insurance company receives a clean claim. Upon claim processing and starting the 61st day from the first statement date, should the Patient or legally designated representative fail to pay XPT&WC the full amount due per XPT&WC's policy, a late fee equal to ten percent (10%) of the amount due shall be added to the claim balance. Additionally, starting on the 61 st day the claim is outstanding until the debt is fully settled, interest shall accrue on all past-due amounts at ten percent (10%) per annum (compounded monthly). In the event of an over-payment, XPT&WC shall have thirty (30) days following the posting of the applicable processed claim to refund the over-payment

D. Credit Card Authorization

In the event the open claim balance has not been satisfied on the sixty first (61st) day from submission to the insurance company, or in the event any check used for payment by Patient is returned or declined due to insufficient funds, XPT&WC is hereby authorized to charge my credit card on file in an amount equal to the full open claim balance. All approved written payment plans are null and void if your Credit Card payment is not approved and payment cannot be collected within twenty-four (24) hours via valid Credit Card _____ (Initial)

E. Patient Discharge / Collections Fees

In the event Patient fails to pay for services rendered, Patient understands that Patient may be discharged from the services of Provider until such time as Patient's account is paid in full. Patient understands and agrees: Failure to maintain a current account may result in suspension or discharge from care. Provider will make reasonable efforts to notify Patient prior to discharge, consistent with clinical judgment and applicable standards. Patient may resume care once account is brought current, subject to Provider availability. Patient accepts responsibility for any consequences resulting from interruption of care due to non-payment.

F. Returned Check Fee

Patient understands that in the event a check used for payment is returned due to insufficient funds, Patient agrees to provide, within twenty-four (24) hours of notice, cash, money order, or certified check for the full amount of the payment owed, in addition to a $50.00 returned check charge. If Patient makes no secondary payment per the terms herein, then Patient hereby authorizes Provider to charge Patient's Credit Card the outstanding amount per the terms of Section "E," hereto

G. Assignment of Benefits

Patient hereby authorizes assignment and/or payment of all Benefits, which are payable to Patient under the terms of Patient's Coverage, to be assigned and/or paid directly to XPT&WC for services rendered, as provided by California State and/or federal prompt pay rules, regulations, and statutes. Patient further consents to the use and disclosure of PHI or any other relevant personal information for the purposes of treatment, payment, and general operations, including but not limited to the processing of all insurance claims. XPT&WC courtesy billing service is limited to billing primary and secondary insurance carriers; all other insurance claims are the patient's responsibility to file. I understand I am responsible for any costs incurred by XPT&WC to adjudicate my claims. Lastly, I understand that I, my heirs and/or assignees are fully responsible for any outstanding charges, including charges for equipment and supplies not paid by my insurance.

H. Missed Appointment Fee

I understand that I will be assessed a $50 fee if I miss a scheduled appointment without having provided a twenty-four (24) hour advance notice of cancellation. We understand that from time to time there may be circumstances that require you to cancel with less than 24 hours' notice. We will determine the fee assessment on a case-by-case basis. Because we do not overbook, giving us as much notice as possible allows us to try to fill your appointment, thereby simply allowing us to waive your fee. "No-Showing" will ALWAYS result in a missed appointment fee assessment. _____ (Initia)

I. Out-of-Network Responsibilities

XPT&WC agrees to accept the amount paid for claim reimbursement when the insurance payer considers XPT&WC an "Out of Network Provider," so long as the amount paid is an accurate payment for the services rendered. Further, the Patient's Out-of-Pocket financial responsibility to XPT&WC will be limited to the amount equal to the Patient's financial responsibility for In-Network providers.

J. Governing Law

This contract shall be governed by the laws of the County of Ventura in the State of California and all applicable federal la ws. In witness of their agreement to the terms above, the parties or their authorized agents hereby affix their signatures:

Patient Printed Name

Agreement Date

Signature of Patient or Authorized Agent

Signature of Provider or Authorized Representative