Xcell Orthopaedics Physcial Therapy
REGISTRATION FORM

Patient ID:

PATIENT INFORMATION

Patient's Name First:	M.I.:	Last:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Preferred Method of Appt Reminders: [ ] Home Phone [ ] Cell Phone [ ] Text [ ] Email [ ] Check Here For No Appt Reminder			
Date of Birth:	Gender:		
Date of Injury:	Place (State) of Injury:		
Emergency Contact:			
Relationship:	Phone: ( )		

PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD

Primary Insurance Company:		ID #:
Name of Subscriber:	Date of Birth:	Group #:
Relationship to Subscriber: (Circle One)	Self / Spouse / Minor / Other	
Employer:	Work Phone:	
Secondary Insurance Company (If Applicable):		ID #:
Name of Subscriber:	Date of Birth:	Group #:
Relationship to Subscriber: (Circle One)	Self / Spouse / Minor / Other	
Employer:	Work Phone:	

GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)

Name Last:	First:	M.I.:	SSN:
Address:	City:	State:	Zip:
Relationship to Subscriber: (Circle One)	Self / Spouse / Other	Date of Birth:	
Employer:	Work Phone:		

CONSENT FOR TREATMENT

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Xcell Orthopaedics Physical Therapy and hereby authorize and give my consent for Xcell Orthopaedics PT to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment. In addition, I understand I will be working with my PT/PTA/Tech team both male and female I give permission to be treated by.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize and give my consent for Xcell Orthopaedics Physical Therapy to treat _____ (minor's name) while I am not present.

Patient / Guardian / Responsible Party Signatur		**Date:**

Xcell Personnel Must fill this portion OUT with the Patient or Caregiver: Patient Criteria:

1. Does patient understand/comprehend communication (either verbal or written) ☐ Yes ☐ No (check)
2. Can Patient follow 1 & 2 step commands. Example "raise your arm" "holddumbell and raise your arm" ☐ Yes ☐ No (check)
3. Can the patient sit upright independently in a chair or wheelchair ☐ Yes ☐ No (check)
4. Can patient stand with assistance (holding on to walker/cane/wheelchair, holding table/wall, holding someone's hand: no more than one person's hand ☐ Yes ☐ No (check)
5. Does the patient have bowel and bladder control (accident do happen but the patient must have the ability to know when they have to use the bathroom). ☐ Yes ☐ No (check)
6. Are you receiving Physical Therapy at home / recibe terapia fisica en casa? ☐ Yes ☐ No (check)

Patient ID:

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

PATIENT INFORMATION CONSENT: I have read and fully understand Xcell Orthopaedics Physical Therapy's Notice of Information Practices. I understand that Xcell Orthopaedics PT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations by notifying the practice. I also understand that Xcell Orthopaedics PT will consider requests for restriction 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 Xcell Orthopaedics Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Initials

ATTENDANCE, CANCELLATION, and NO SHOW: Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require at least 24 hours notice of cancellation. There is a $20 charge for cancellation without prior notice or for not showing for your appointment. This charge is not covered by insurance, and you are required to pay this fee personally.

_____
Initials

FINANCIAL RESPONSIBILITY: As a courtesy to you, Xcell Orthopaedics Physical Therapy will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. Xcell Orthopaedics PT is not responsible for issues between the patient and insurance carrier, nor can Xcell Orthopaedics PT intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, Xcell Orthopaedics PT requires payment by the patient for any equipment/supply at the time the order is placed. Xcell Orthopaedics PT will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. Xcell Orthopaedics PT accepts cash, visa, mastercard, or discover as payment options.

_____
Initials

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION

I hearby authorize Xcell Orthopaedics PT to share any and all of my medical / billing information with the following people:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

PATIENT AUTHORIZATION

- By my initials and signature I understand these policies and my financial obligations for services rendered.

- I hereby assign payment of benefits by my insurance company to Xcell Orthopaedics Physical Therapy, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.

- I hereby agree to pay any office visit/co-payment charges at time of visit.

- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

Patient Signature: _____ **Date:** _____

Parent / Guardian / Guarantor: _____ **Date:** _____