PLEASE SIGN
BY EACH "X"

Excel Physical Therapy, LLC

DATE: ______ / _______/ ________

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED

I authorize payment of medical benefits to Excel Physical Therapy, LLC for these services and all future claims.	I authorize the release of medical information necessary to process this claim and all future claims.	I have been provided with the Notice of Privacy Practices for Excel Physical Therapy, LLC and have had the opportunity to review it.
X ____________________________________	X ____________________________________	X ____________________________________
Signed (Insured or Authorized Person)	Signed (Insured or Authorized Person)	Signed (Insured or Authorized Person)

PATIENT INFORMATION

Last Name ______ First Name ______ Middle Initial ______ Nickname_ ______

Mailing Address ______ City ______ State ______ Zip ______

Sex (circle one): Male Female

Date of Birth: _______/ _______/ __________

Home Phone: ( ) _________ - ____________

Marital Status (circle one): S M X D W

Currently Employed? YES NO

Cell Phone: ( ) _________ - ____________

Soc. Sec. Number: ________- ________- ___________

Employer ______

Work Phone: ( ) _________ - ____________

Email: ____

SPOUSE / RESPONSIBLE PARTY

Last Name ______ First Name ______ Middle Initial ______ Nickname ______

Mailing Address ______ City ______ State ______ Zip ______

Sex (circle one): Male Female

Date of Birth: _______/ _______/ __________

Home Phone: ( ) _________ - ____________

Marital Status (circle one): S M X D W

Currently Employed? YES NO

Cell Phone: ( ) _________ - ____________

Soc. Sec. Number: ________- ________- ___________

Employer ______

Work Phone: ( ) _________ - ____________

EMERGENCY CONTACT AND/OR NEXT OF KIN / REFERRING PHYSICIAN

Name: ____ Relationship: _________________________________ Phone: ( ) _________ - ____________

Physician Last Name: __________________________________ First Name: __________________________________ Phone: ( ) _________ - ____________

INSURANCE INFORMATION

In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be completely filled out.

Does the Patient have health insurance? (circle one) YES NO

Date of Injury or Onset: ________/ _________/ __________

Is this visit related to an accident? (circle one) WORK COMP AUTO OTHER

Claim Number: ____

PRIMARY INSURANCE CARRIER	OTHER INSURANCE CARRIER
Company Name: ______________________________	Company Name: ______________________________
Address: ______________________________	Address: ______________________________
City ______ State ______ Zip ______	City ______ State ______ Zip ______
Phone: ( ) _________ - ____________	Phone: ( ) _________ - ____________
ID# / Subscriber Number ______ Policy / Group Number ______	ID# / Subscriber Number ______ Policy / Group Number ______
Policy Holder Name: ______________________________	Policy Holder Name: ______________________________