



Patient Registration

PATIENT INFORMATION			
Last Name:	First Name:	MI	Today Date:
Address	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	Ext:
Email Address:			
Social Security Number:	Birth Date:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
EMPLOYMENT or SCHOOL INFORMATION			
Employer or School:	Status:	Title/Position:	
	<input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> N/A		
Work Address:	City:	State:	Zip:
Employer Phone:	Employer Contact:	Email Address (optional):	
REFERRING PHYSICIAN INFORMATION			
Physicians Name:	Phone:	Address:	
EMERGENCY INFORMATION			
Parent or Contact Last Name:	First Name:	MI	Relationship:
Address	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	Ext:
RESPONSIBLE PARTY INITIALS :		TODAY'S DATE:	



Patient Registration

PRIMARY INSURANCE COMPANY INFORMATION

Primary Insurance Company Name:	Insurance ID Number:	Group Number:	Phone:
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POLICYHOLDER (If Other than Patient)

Last Name:	First Name:	MI:
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Social Security Number:	Birth Date:	Sex:	Relationship to Patient:
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Home Phone:	Employer:	Work Phone:
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SECONDARY INSURANCE COMPANY INFORMATION

Secondary Insurance Company Name:	Insurance ID Number:	Group Number:	Phone:
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POLICYHOLDER (If Other than Patient)

Last Name:	First Name:	MI:
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Social Security Number:	Birth Date:	Sex:	Relationship to Patient:
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Home Phone:	Employer:	Work Phone:
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ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Xcel Sports Medicine LLC in the event that they file insurance claims on my behalf. In the event that my account becomes delinquent and is in default of payment, I accept responsibility for the principal amount owed as well as reasonable costs associated with collection of the debt. Costs of collection include but are not limited to collection service fees, attorney's fees, court costs and other legal fees associated with collection of this debt. Interest may be assessed at the rate of 1.5% per month (18% annual or as limited by law) for unpaid balances over 90 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Xcel Sports Medicine LLC as may be dictated by prudent medical practice for treatment of my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Init () I AM RESPONSIBLE FOR CO-PAYMENTS AT TIME OF SERVICE, DEDUCTIBLES AND CO-INSURANCE.

Init () I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT PAID BY INSURANCE.

CANCELLATION and NO SHOW POLICY: Our goal and yours is to improve your condition. To achieve that goal, it is important that you attend all of the sessions according to the physical therapy plan determined by your physician and therapist. In consideration of others, we request that you arrive on time for appointments. If you cannot make an appointment, please give us a 24 hour notice so that another patient may be scheduled. Habitual violation of this policy will alter your choices for your next appointment..

Init () I ACKNOWLEDGE THAT XCEL MAY LIMIT APPOINTMENTS IF I VIOLATE THE NO SHOW POLICY.

Init () I HAVE RECEIVED THE PATIENT COPY OF MY HIPAA RIGHTS AND XCEL BILLING POLICIES

Authorized Signature:	Today's Date:
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