5899 Whitfield Ave Ste 202
Sarasota, FL 34243
Tel: 941-360-1988
Fax: 941-360-1998

Outpatient Clinics

PATIENT REGISTRATION

Medicare: ____ Commercial Insurance: ____ Auto: ____ Worker's Comp: ____ Other: ______________________

Patient's Name: ____ Sex: ______ Date of Birth: ____/____/_______

Address: ____

City: _________________________ State: ______ Zip code: __________ Home Phone #: (____) _______________

Cell Phone #: (____) ____________ Email Address: ____

Other Address: ____________________________________ City: _______________ State: ____ Zip code: _______

Social Security #: ___________________________ Drivers License #: _______________________________________

Occupation: ___________________________ Employer name and phone #:__________________________________

Primary Physician: ______________________________ Specialist Physician: _________________________________

EMERGENCY CONTACT: _______________________________**PHONE** #: _____________________________

RELATIONSHIP: _________________________

Who referred you to Excell Rehab? Physician: _____ Friend: _____ Yellow Pages: _____ Other: ______________

Have you had Physical, Occupational or Speech Therapy since January, 2010? _______________________________

If you are coming to therapy due to auto or work related accident, what was the date of your injury? _____________

Are you currently or have you been followed by a Home Health Agency? ___________________________________

If so, please specify which Home Health Agency and how many visits? _____________________________________

Name of Guarantor if other than patient _________________________ Parent ____ Guardian ____ Other _________

Social Security #: ___________________________ Drivers License #: _______________________________________

Address: ____ City: ____________ State: _____Zip code: ___________

*** Please give the receptionist your health insurance cards and a photo ID.**

Patient's Signature: _________________________________

Excell Rehab
Outpatient Clinics

5899 Whitfield Ave Ste 202
Sarasota, FL 34243
Tel: 941-360-1988
Fax: 941-360-1998

MEDICAL INFORMATION

Name: ____ Age: __________ Date: _______________

Physician: __________________________________ Diagnosis: ___________________________________

Date of injury: _______________ Method of Injury: ____

Medications: ____

Check medical conditions you have been treated for:

Arthritis	Diabetes	Neurological Problems
Cardiac Problems	High Blood Pressure	Pacemaker / Defibrillator
Circulatory Problems	Incontinence	Stroke
Cancer / Type: _____________	Joint Replacement: _____________	

Any surgeries related to above conditions? ____

Activities prior to injury/surgery:	Occupational:	light	moderate	heavy	N/A
	Recreational:	light	moderate	heavy	N/A
Current activities:	Occupational:	light	moderate	heavy	N/A
	Recreational:	light	moderate	heavy	N/A

What is the location of the pain or discomfort we are seeing you for? ___________________________________

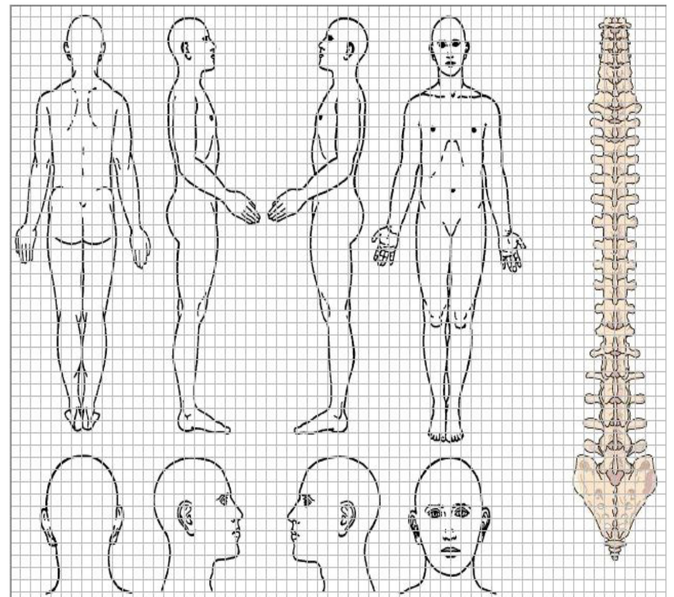
Pain/discomfort is:	constant	intermittent	dull	sharp
	shooting	burning	throbbing	other:______________________________

Please rate your pain on a scale of 0 to 10
(0= no pain, 10= worse pain)

0 1 2 3 4 5 6 7 8 9 10

What makes your pain better? ________________________
What makes your pain worse? ________________________

Please use the body chart on the right to indicate the location of your symptoms (xxx = pain ooo = numbness or tingling)



Patient's Signature: ______________________________

Excell Rehab
Outpatient Clinics

5899 Whitfield Ave Ste 202
Sarasota, FL 34243
Tel: 941-360-1988
Fax: 941-360-1998

Patient's name: ____ Date: ___________________

Insurance name: _____________________________ Ins ID #: ________________________________

Group #: ____________________________________ SS #: ___________________________________

I hereby instructed and direct _______________________ Insurance Company to pay by check made out and mailed to: Maxider Corporation, PO Box 21075, Sarasota, FL 34276.

Or, if my current policy prohibits direct payment to provider, I hereby also instruct and direct ________________Insurance Company to make out the check to me and mail it as follows:

____

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I authorize treatment, and agree to allow Excell Rehab to file claims to the insurance company on my behalf. Excell Rehab will file claims to insurance accordingly, however, if payment is not received within 60 days, the balance will be my responsibility (Workman Comp and Auto Insurance with LOP are exempt). **It is my responsibility to know and understand my insurance benefits. This includes deductibles, participating providers, limitations on payments, number of visits, co-pays and co-insurance information. Any balance not paid by my insurance is my responsibility.** If the insurance company reimburses me for services provided by Excell Rehab, it is my responsibility to sign over check to "Maxider Corporation" and send to its office along with payment statement.

I also am authorizing the release of any information on my treatment that may be required to process my claim to any insurance company, attorney and/or physician.

Please respect your appointment time. If you are unable to make it, please notify us 24 hours in advance. A $25 fee will be charged for NO SHOWS. Thank you.

By signing below, I agree in all above statements regarding my insurance benefits and also I acknowledge that I received the **NOTICE OF PRIVACY PRACTICE** and have had an opportunity to read it.

Patient's Signature ____ **Date:** ___________________
Policyholder

Claimant Signature: ____ **Date:** ___________________
If other than Policyholder

Parent or Legal Guardian ___________________________________ **Date:** ___________________