830 Falls Creek Drive
Vandalia, OH 45377
(937)890-9235

515 East Main St. D
Anna, OH 45302
(937)639-2063

3878 Indian Ripple Rd.
Beavercreek, OH 45440
(937)702-9735

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New Patient Registration Packet

This Patient Registration Packet includes the following:

1. Patient Registration Sheet (page 1)
   - This form is for patient demographic and physician referral information.
   - Patient must initial the two boxes at bottom acknowledging and understanding the cancellation policy and HIPAA Rights and Xcel billing policies.
   - The patient must sign and date the bottom of this form
2. Patient Registration Sheet (page 2)
   - Patient is required to bring their insurance card(s) and a form of identification (ie. drivers' license)
   - This form is for patient's primary and secondary insurance information
   - The patient must list all subscriber information if different than patient, including name, date of birth and social security number.
   - Patient must initial the three boxes at bottom acknowledging and understanding responsibility for copayments, deductibles and co-insurance charges at time of service as well as insurance visit requirements (script referral, authorization, and/or visit limits).
3. Insurance Subscriber vs. Guarantor Agreement (page 3)
   - This agreement relates to the payment responsibilities for a minor receiving treatment. You are required to complete only if it pertains to you.
4. Medical History
   - This form is for patient to list all medical history.
5. Patient Medication List
   - This form is for patient to list all medications, the dosage and how the medicine is administered, (ie. via mouth, injection, topical, etc.)
   - This information assists the Therapist in the evaluation and treatment of the patient
6. HIPAA Acknowledgement and Release Form
   - Each patient is required to complete and sign this Privacy Practices and Consent form, to include listing those individual who can have access to their health information and/or emergency contacts. A copy of the HIPAA Notice of Privacy Practices is located on our website, in the lobby or upon request from Reception.
7. Notice of Patient Appointment and Billing Practices
   - This is a patient copy of Xcel Sports Medicine's policies regarding cancelled and no show appointments as well as the claims and billing polices. Patient must sign and will receive a copy.
8. Surviving Physical Therapy
   - This is a brief overview of what to expect at your first physical therapy appointment and who to contact if you have any questions.

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PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: **First Name:** **MI** **Today's Date:** / /

Address **City:** **State:** **Zip:**

Home Phone: ( ) - **Cell Phone:** ( ) - **Work Phone:** ( ) - **Ext:**

Email Address:

Social Security Number: - - **Birth Date:** / / **Sex:** ☐ Male ☐Female

EMPLOYMENT OR SCHOOL INFORMATION

Employer or School: **Status:** ☐Full ☐Part ☐N/A **Title/Position:**

Work Address: **City:** **State:** **Zip:**

Employer Phone: ( ) - **Employer Contact:** **Email Address (optional):**

REFERRING PHYSICIAN INFORMATION

Physicians Name: **Phone:** ( ) - **Address:**

CANCELLATION and NO SHOW POLICY: A $50 fee will be charged to your account for a cancellation and no-show appointment if you do not give us 24 HOURS notice prior to your appointment. In consideration of others, we request that you arrive on time for appointments.

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.
The entire Xcel staff thanks you for your consideration. *We will never charge you a fee for missing an appointment provided you give us 24 hours notice.*

Init ( ) I ACKNOWLEDGE THAT XCEL WILL CHARGE $50 FOR A CANCELLATION AND NO SHOW APPOINTMENT WITHOUT 24 HOURS NOTICE. XCEL MAY ALSO LIMIT APPOINTMENTS IF I VIOLATE THIS POLICY.

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

RESPONSIBLE PARTY SIGNATURE **TODAY'S DATE**

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PATIENT REGISTRATION

PRIMARY INSURANCE COMPANY INFORMATION

Primary Insurance Company Name: | **Insurance ID Number:** | **Group Number:** | **Phone:** ( ) -

POLICYHOLDER/GUARANTOR (If Other than Patient)

Last Name: | **First Name:** | **MI:**

Address: | **City:** | **State:** | **Zip:**

Social Security Number: - - | **Birth Date:** / / | **Sex:** M F | **Relationship to Patient:**

Home Phone: ( ) - | **Employer:** | **Work Phone:** ( ) -

SECONDARY INSURANCE COMPANY INFORMATION

Secondary Insurance Company Name: | **Insurance ID Number:** | **Group Number:** | **Phone:** ( ) -

POLICYHOLDER/GUARANTOR (If Other than Patient)

Last Name: | **First Name:** | **MI:**

Address: | **City:** | **State:** | **Zip:**

Social Security Number: - - | **Birth Date:** / / | **Sex:** M F | **Relationship to Patient:**

Home Phone: ( ) - | **Employer:** | **Work Phone:** ( ) -

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 principle 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, DEDUCTIBLES AND CO-INSURANCE AT TIME OF SERVICE .

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

Init ( ) I AM RESPONSIBLE TO KNOW AND UNDERSTAND MY INSURANCE VISIT REQUIREMENTS INCLUDING NEEDING A SCRIPT REFERRAL AND/OR AUTHORIZATION, AS WELL AS MY VISIT LIMITS FOR THE PLAN OR CALENDAR YEAR.

Authorized Signature: _____ **Today's Date:**

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PATIENT REGISTRATION

Policy Regarding Insurance Subscriber vs. Guarantor

(In the event of a minor receiving treatment)

- **Insurance Subscriber:** The individual who pays the insurance premiums and the individual who carries the minor on their insurance.

- **Patient Guarantor:** The individual responsible for the patient's bills, and/or the individual that completes/signs the registration paperwork, and initials off as the responsible party of any copays, deductibles, or co-insurances on the insurance information page.

** **Insurance Subscriber vs. Guarantor:** These individuals are NOT one in the same. The insurance subscriber is not and will not be automatically considered as the guarantor. Xcel Sports Medicine will consider the party who is above defined as the Patient Guarantor, the one responsible for any fees and/or balance remaining once the insurance has processed.

**** In the situation of a specific divorce decree that outlines the responsible parties' medical bill responsibility, if different than defined above, we ask that a copy of that be provided to our office at the start of the patients treatment. Please note that ultimately both parties are jointly and severally liable for payment to Xcel Sports Medicine, LLC.**

I _____, understand my financial responsibility, as defined above, for any balance remaining on _____ Xcel Sports Medicine account after insurance processes as necessary.

Date:_____

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MEDICAL HISTORY

Date:		
Name:		
Are you currently taking any medications? **Medication Details (Please list on second page)**	**YES** ☐	**NO** ☐
Do you have any allergies to medication or otherwise? **List Allergies:**	**YES** ☐	**NO** ☐
Have you had surgery in the last year? **List type of surgery and details:**	**YES** ☐	**NO** ☐
Have you been treated in the Emergency Room in the past 3 months or admitted to the hospital? **When?** **Reason?**	**YES** ☐	**NO** ☐
Have you fallen in the last 12 months? **If yes, were you injured?** **Describe:**	**YES** ☐ **YES** ☐	**NO** ☐ **NO** ☐

Chest Pain	**YES** ☐	**NO** ☐	Diabetes	**YES** ☐	**NO** ☐
Heart attack	**YES** ☐	**NO** ☐	Cancer	**YES** ☐	**NO** ☐
Coughing	**YES** ☐	**NO** ☐	Metal Implants (plates,pins)	**YES** ☐	**NO** ☐
Pacemaker	**YES** ☐	**NO** ☐	Epilepsy	**YES** ☐	**NO** ☐
High Blood Pressure	**YES** ☐	**NO** ☐	Shortness of Breath	**YES** ☐	**NO** ☐

Have you ever been diagnosed with any of the following conditions?

Are there any other conditions or illnesses that you feel we should know about? **Describe:**	**YES** ☐	**NO** ☐

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PATIENT MEDICATION LIST

You are required to list any current prescribed, over the counter medications, herbals and supplements you are taking. Please list them below with dosage and how they are taken.

Medication Name	Dosage	Frequency	Route (Oral, Injected, Topical)

FOR INTERNAL USE ONLY	BMI (Measurements)
Height	
Weight	

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NOTICE OF PATIENT APPOINTMENT AND BILLING PRACTICES

THIS NOTICE DESCRIBES HOW APPOINTMENT AND BILLING POLICIES ARE ADMINISTERED AND HOW INSURANCE CLAIMS MAY AFFECT YOU. PLEASE REVIEW THIS INFORMATION CAREFULLY.

CLAIMS AND BILLING – You have agreed as follows:
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.

You have assigned your medical benefits for insurance claims to Xcel Sports Medicine LLC, hereinafter referred to as Xcel. By assigning those benefits to Xcel, you have asked that Xcel submit claims for insurance benefits on your behalf and have assigned the payment of those benefits to Xcel. Your insurance company or companies will process the claim and at their sole discretion determine your eligibility for payments. The actual benefit paid is per contract between you and your provider. As such the provider establishes your co-payment (the amount you must pay at the time of your appointment), your deductible (the amount you must pay before the insurance company will pay benefits), and your co-insurance (the amount you must pay that the insurance company assigns as your portion to pay).

Per contract between Xcel and each insurance company, Xcel MUST collect all co-payments at the time of service. Xcel is also required to collect deductibles and co-insurance as assigned and allowed by the insurance provider. You have agreed to pay all co-payments, all co-insurance and all deductibles.

BENEFITS AND ELIGIBILITY: If you have questions about how your insurance company has processed your claim as evidenced in the Explanation of Benefits, you should contact your insurance provider. You are responsible to know and understand your insurance physical therapy visit requirements: including the need for a script referral and/or authorization, as well as the visit limits for the plan or calendar year. For further information on your Xcel Account Balance, or if you would like to discuss your account, please contact our Billing office at (937)890-9235.

CANCELLATION AND NO SHOW POLICY - You have agreed as follows:
A $50 fee will be charged to your account for a cancellation and no-show appointment if you do not give us 24 HOURS notice prior to your appointment.

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 abuse this policy by repeatedly canceling or failing to show for appointments we reserve the right to restrict appointments. You will be allowed to make appointments by calling on the day of service only (you will be given an appointment only if an appointment slot is available) or in egregious cases we may terminate treatment and discharge you

We will never charge you a fee for missing an appointment provided you give us 24 hours notice.

Patient Signature **Date**

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS, COACHES AND/OR TEACHERS IN THE FUTURE.

_____ Please ***print*** your name

_____ Please ***sign*** your name

_____ Legal Representative

_____ Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION/EMERGENCY CONTACT: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.