

**Xcel Physical Therapy  
Patient Registration Form**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_  
Home (Local) Address: \_\_\_\_\_ City: \_\_\_\_\_  
Secondary Address (street address/city/state/zip): \_\_\_\_\_  
Email (optional): \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ Subscriber: self\_\_\_ spouse \_\_\_ parent \_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Subscriber: self\_\_\_ spouse \_\_\_ parent \_\_\_\_  
Friend/relative in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary / Family Physician: \_\_\_\_\_  
Case Manager (typically with auto or work injuries): \_\_\_\_\_  
Case Manager Phone #: \_\_\_\_\_  
Injured body part(s): \_\_\_\_\_

Circle all that apply: Pain      Swells      Catches      restricts mobility      gives out

I assign directly to Xcel Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Xcel Physical Therapy to release all information necessary to secure the payment of benefits, including but not limited to your (patient) insurance or third party payor. I authorize the use of this signature on all of my insurance submissions. I have no mental or cognitive issues that would preclude me from authorizing treatment, or accurately fill out the documentation, or understand my rights as a patient.

**Parent/Legal Guardian/or person 18 years old or older must sign the following:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Initial the following:

\_\_\_\_\_ I consent to the evaluation and on going treatment of physical and/or occupational therapy services at Xcel Physical Therapy. I may decline any intervention at any time by verbalizing my wishes to my therapist.

\_\_\_\_\_ I have had the opportunity to review the HIPPA Privacy and Disclosure Notice at Xcel Physical Therapy and agree to the release of information as stated in that notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_