South Aiken Physical Therapy, LLC dba

South Aiken Physical Therapy & Wellness

Express Registration

Date:

IMPORTANT: Please fill this form out completely and legibly. Thank You.

1. Patient Info

_____ _____ _____

LAST NAME FIRST NAME DATE OF BIRTH

_____ _____ _____ _____

STREET ADDRESS CITY STATE ZIP CODE

(_____)_____ (_____)_____ _____

HOME PHONE CELLULAR PHONE EMAIL ADDRESS

_____ _____ (_____)_____

OCCUPATION EMPLOYER NAME PHONE #

_____ (_____)_____ _____

EMERGENCY CONTACT PERSON PHONE # SOCIAL SECURITY # (ONLY IF INJURED ON JOB)

WORK STATUS: o CURRENTLY EMPLOYED o RETIRED o DISABLED o STUDENT o OTHER

GENDER: o MALE o FEMALE

2. Payment Info

I AM PAYING TODAY BY (CHECK ONLY ONE)…

0 ***INSURANCE*** AND WOULD LIKE TO…
____HAVE YOU DEAL DIRECTLY WITH THEM. I WILL ASSIGN MY BENEFITS TO YOU BY SIGNING THE "ASSIGNMENT OF BENEFITS" FORM.

- MY COINSURANCE/COPAY IS $_____
- MY DEDUCTIBLE IS $_____

0 ***WORKERS COMP***…I WAS INJURED ON THE JOB AND MY EMPLOYER WILL BE RESPONSIBLE
ADJUSTER NAME_____
ADJUSTER PHONE_____

0 ***CASH, CHECK OR CREDIT*** AND WOULD LIKE A…
____30 % DISCOUNT BY PAYING AT THE TIME OF SERVICE
___PAYMENT PLAN (FEES MAY APPLY)

3. Referral Info

HOW DID YOU HEAR ABOUT US?

o I HAVE BEEN HERE BEFORE o INTERNET
o FRIEND/FAMILY o BROCHURE
o ADVERTISEMENT o GOOGLE
o INSURANCE/DIRECTORY o WORKSHOP
o PHYSICIAN/DENTIST/CHIROPRACTOR/NURSE
o OTHER:

_____

WHO CAN WE THANK FOR REFERRING YOU HERE?

4. Important Info

WE ARE VERY COMMITTED TO YOU AND YOUR GOALS. WE WILL RESERVE APPOINTMENT TIMES FOR YOU THAT ALLOW YOU THE APPROPRIATE AMOUNT OF THERAPIST TIME FOR YOUR NEEDS. **IF YOU CANNOT KEEP YOUR APPOINTMENT, PLEASE CALL WITH 24 HOURS NOTICE IF POSSIBLE SO THAT SOMEONE ELSE MIGHT BENEFIT FROM THAT TIME. FAILURE TO PROVIDE 24 HOURS NOTICE WILL RESULT IN A FEE TO YOU.** *NOTHING WILL BE CHARGED UNLESS YOU CANCEL WITH LESS THAN A 24-HOUR ADVANCE NOTICE ($10 FEE) OR FAIL TO SHOW ($25 FEE).*

5. Appointment Reminders

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS FOR YOUR FUTURE VISITS? o YES o NO

IF YES, PLEASE CHECK THE ONE METHOD YOU PREFER (IF CONTACT INFO DIFFERS FROM LISTED ABOVE, PLEASE SPECIFY BELOW)

oTEXT MESSAGE
oVOICE CALL TO MY o CELL PHONE o HOME PHONE
o EMAIL

Pre-Exam Questionnaire

Welcome! To help us deliver you the very best care possible please fully complete this questionnaire.

Patient Name: _____ Date of Birth: _____

What is the main problem we are seeing you for today? _____

_____

When did this problem start? _____

Did you have surgery for this problem? O Yes O No If yes, when? _____

What procedure? _____

Of the following activities and tasks listed below, which are difficult to do or are you unable to do because of your current problem? Please check the applicable box(es).

- O Dressing
- O Bathing
- O Toileting
- O Sleeping
- O Driving
- O Ability To Handle Phone
- O Cooking
- O Laundry
- O Volunteer
- O Caregiving

- O Remaining Standing
- O Squatting
- O Kneeling
- O Sitting
- O Standing
- O Move From Bed To Chair
- O Turning In Bed
- O Rising From A Chair

- O Need For Assistive Device
- O Walking Forward, Back Or Sideways
- O Walking Around Obstacles
- O Climbing
- O Running/Jogging/Skipping/Jumping
- O Swimming
- O Walk In Home
- O Stairs
- O Walk In Community
- O Walk In Large Building
- O Walking On Uneven Terrain

- O Pulling Objects
- O Pushing Objects
- O Reaching
- O Turning Or Twisting Hands Or Arms
- O Throwing
- O Catching
- O Picking Up Small Items
- O Gripping Objects
- O Manipulating Small Items
- O Releasing Small Objects
- O Kicking
- O Work
- O Wellness/Recreation

Did you have difficulty with any of the above activities before this problem? O Yes O No If yes, please explain below:

_____

If we are seeing you for a pain problem today, please tell us more about it:

Where is your pain? _____

How would you rate your pain on a scale of 0-10 (0 is no pain, 5 is moderate pain, 10 is excruciating pain)?

At Worst_____, Currently _____, At Best _____

South Aiken Physical Therapy. LLC dba South Aiken Physical Therapy and Wellness
943 Pine Log Road, Aiken SC 29803 phone (803) 649 9797 fax (803) 642 2759
email: help@southaikenpt.com www.southaikenpt.com

form rev 2/2018

Pre-Exam Questionnaire

Describe your pain further by checking all applicable descriptions:

- O Burning
- O Sharp
- O Dull/Achy
- O Throbbing
- O Shooting
- O Numb/Tingle
- O Constant
- O Intermittent
- O Worse in AM
- O Worse in PM
- O Worse at Night
- Other:_____

How would you describe your general health? O Good O Fair O Poor O Other:_____

Please tell us more about your Medical History. Please check any that apply:

- O I have no Known past medical history to affect treatment
- O Alzheimer's
- O Cardiovascular Disease
- O Pacemaker
- O Hypertension
- O Stroke
- O Diabetes Type 1
- O Diabetes Type 2
- O Fibromyalgia
- O History of Cancer
- O Immunosuppression
- O Lupus
- O Muscular Dystrophy
- O Obesity
- O Osteoarthritis
- O Parkinson's
- O Rheumatoid Arthritis
- O Traumatic Brain Injury
- O Other:_____

If you have had any diagnostic tests for this problem please note results here: (i.e. Xray, MRI, CT scans)

_____

Do you have any unexplained weight loss? O Yes O No

Are you currently taking any medications (prescription, herbal or over the counter)? O Yes O No If yes please list below: O I have provided a separate medication list

_____

List one or two things you are having difficulty doing now that you would like to be able to do better after Physical Therapy;

1. _____

2. _____

_____ _____

Signature (parent/guardian if under 18) Date

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Important Information

Please read the following and sign below to acknowledge that you understand and agree to the following:

CONSENT TO TREAT

The undersigned grants authority to South Aiken Physical Therapy, LLC (SAPT) and its staff to perform procedures and treatments deemed necessary for this patient and generally are used in the care of patients in this and similar Physical Therapy facilities. Additionally, the undersigned grants permission for the SAPT staff to provide emergency treatment if it is needed, or to transfer this patient to a local hospital for emergency treatment deemed necessary by the hospital medical staff.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The undersigned acknowledges that he/she has been provided the option to receive a copy of the South Aiken Physical Therapy Notice of Privacy Practices. I understand that SAPT has the right to change its Notice of Privacy Practices and that I may contact SAPT at any time to obtain a current copy of the Notice of Privacy Practices.

ASSIGNMENT OF INSURANCE BENEFITS (CHECK ONE)

O ***I AM PAYING CASH FOR MY SERVICES. THIS DOES NOT APPLY TO ME***

O ***I WANT YOU TO DEAL DIRECTLY WITH MY INSURANCE***

The undersigned hereby instructs and directs my insurance company to pay by check made out and mailed to: South Aiken Physical Therapy, 943 Pine Log Road, Aiken, SC 29803. This is a direct assignment of my rights and benefits under my policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I agree that: a photocopy of this Assignment shall be considered as effective and valid as the original, I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster or attorney involved in this case for the purpose of processing claims and securing payment of benefits, I authorize the use of this signature on all insurance submissions, I authorize South Aiken Physical Therapy, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf, I understand that I am financially responsible for all charges whether or not paid by insurance.

If Policy Holder is different than patient please provide the following information:

*Policy Holder Name*_____ *Policy Holder Date of Birth:*_____

PLEASE SIGN:

_____

Signature of Patient (Required)/Date

_____

Signature of Representative (Where Required)/Date

Office Use Only:

Initials:_____ Date:_____