



# Express Registration

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

Please fill in completely and legibly. Loyal Patient, if your information has not changed please fill in your name and DOB in Section 1 then skip to complete Sections 2-5.

## 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:  CURRENTLY EMPLOYED  RETIRED  DISABLED  STUDENT  OTHER

GENDER:  MALE  FEMALE

## 2. Payment Info

**I AM PAYING TODAY BY (CHECK ONLY ONE)...**

- 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 \$\_\_\_\_\_
- WORKERS COMP**...I WAS INJURED ON THE JOB AND MY EMPLOYER WILL BE RESPONSIBLE  
**ADJUSTER NAME** \_\_\_\_\_  
**ADJUSTER PHONE** \_\_\_\_\_
- 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?**

- I HAVE BEEN HERE BEFORE
- INTERNET
- FRIEND/FAMILY
- BROCHURE
- ADVERTISEMENT
- GOOGLE
- INSURANCE/DIRECTORY
- WORKSHOP
- PHYSICIAN/DENTIST/CHIROPRACTOR/NURSE
- 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). REPEATED CANCELS/NO SHOWS WILL NEGATIVELY AFFECT YOUR OUTCOME AND MAY LEAD TO AN EARLY DISCHARGE FROM PT.**

## 5. Appointment Reminders

CAN WE SEND YOU APPOINTMENT REMINDERS FOR YOUR FUTURE VISITS?  YES  NO

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

- TEXT MESSAGE
- VOICE CALL TO MY  CELL PHONE  HOME PHONE
- EMAIL



## 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)

I Am Paying Cash For My Services this does not apply (skip to Acknowledgement of Financial Policies)

I Want You To Deal Directly With My Insurance

The undersigned hereby instructs and directs my insurance company to pay South Aiken Physical Therapy (SAPT), 943 Pine Log Road, Aiken, SC 29803. This is a direct assignment of my rights and benefits under my policy. I understand the amount I pay is a contract between me and my insurance company. SAPT will deal directly with my insurance company for payment and for handling disputes. I understand that non-covered services are my responsibility (we will let you know if we think your services may not be covered). 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: \_\_\_\_\_

### Acknowledgement of Financial Policies

The undersigned accepts responsibility for payment of services rendered and will make payment at the time of service. Please understand that we are required to collect your portion of the invoice at the time of service and we cannot waive or discount our fees except for documented financial hardship (per federal guidelines – ask for an application at the front desk if you think you qualify). Payment is accepted in the form of cash, check, Master Card, Visa and Discover. It is important to us that you get the care that you need so if you are unable to pay at the time of service you have the option to file a Request for Payment Extension Form (there is a \$7.00 fee for this service). Individualized payment plans are also available (for a one time \$29 fee). Please also note that accounts 30 days past due will be subject to 9.9% interest per month and a \$25 fee for returned checks.

### PLEASE SIGN:

\_\_\_\_\_  
Signature of Patient (Required)/Date

\_\_\_\_\_  
Signature of Representative (Where Required)/Date

### Office Use Only:

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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?  Yes  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).

- |   |  |
|---|--|
| <input type="radio"/> Dressing                            | <input type="radio"/> Remaining Standing     |
| <input type="radio"/> Bathing                             | <input type="radio"/> Squatting              |
| <input type="radio"/> Toileting                           | <input type="radio"/> Kneeling               |
| <input type="radio"/> Sleeping                            | <input type="radio"/> Sitting                |
| <input type="radio"/> Driving                             | <input type="radio"/> Standing               |
| <input type="radio"/> Cooking                             | <input type="radio"/> Move From Bed To Chair |
| <input type="radio"/> Laundry                             | <input type="radio"/> Turning In Bed         |
| <input type="radio"/> Volunteer                           | <input type="radio"/> Rising From A Chair    |
| <br>  |  |
| <input type="radio"/> Need For Assistive Device           | <input type="radio"/> Pulling Objects        |
| <input type="radio"/> Walking                             | <input type="radio"/> Pushing Objects        |
| <input type="radio"/> Walking Around Obstacles or outside | <input type="radio"/> Reaching               |
| <input type="radio"/> Climbing                            | <input type="radio"/> Throwing               |
| <input type="radio"/> Running/Jogging/Skipping/Jumping    | <input type="radio"/> Catching               |
| <input type="radio"/> Stairs                              | <input type="radio"/> Picking Up Small Items |
| <input type="radio"/> Walk In Community                   | <input type="radio"/> Gripping Objects       |
| <input type="radio"/> Walk In Large Building              | <input type="radio"/> Work                   |
| <input type="radio"/> Walking On Uneven Terrain           | <input type="radio"/> Wellness/Recreation    |

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 \_\_\_\_\_

Describe your pain further by checking all applicable descriptions:

- |                                 |                                    |                                      |
|---------------------------------|------------------------------------|--------------------------------------|
| <input type="radio"/> Burning   | <input type="radio"/> Shooting     | <input type="radio"/> Worse in AM    |
| <input type="radio"/> Sharp     | <input type="radio"/> Numb/Tingle  | <input type="radio"/> Worse in PM    |
| <input type="radio"/> Dull/Achy | <input type="radio"/> Constant     | <input type="radio"/> Worse at Night |
| <input type="radio"/> Throbbing | <input type="radio"/> Intermittent | Other: _____                         |

How would you describe your general health?  Good  Fair  Poor  Other: \_\_\_\_\_

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

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

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

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Do you have any unexplained weight loss?  Yes  No

Have you had any falls in the past 12 months?  Yes  No If Yes, how many falls have you had? \_\_\_\_\_

Were you injured in the fall(s)?  Yes  No

Are you currently taking any medications (prescription, herbal or over the counter)?  Yes  No If Yes, please list below and include if you take by mouth, topically, injection, etc.

I have provided a separate medication list

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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

**OFFICE USE ONLY:** Height (inches) \_\_\_\_\_ Weight (pounds) \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_  Patient refused height and weight measurement  Not Safe to Weigh Patient  
 (N = Age 65 & older BMI ≥ 23 and < 30 kg/m<sup>2</sup> ; Age 18 – 64 BMI ≥ 18.5 and < 25 kg/m<sup>2</sup>)