South Aiken Physical Therapy & Wellness

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: 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)…

- o ***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 $_____
- o ***WORKERS COMP***…I WAS INJURED ON THE JOB AND MY EMPLOYER WILL BE RESPONSIBLE
  ADJUSTER NAME_____
  ADJUSTER PHONE_____
- o ***I AM NOT USING INSURANCE AND WILL BE PAYING BY CASH, CHECK OR CREDIT AT THE TIME OF SERVICE AND WILL BE CHARGED THE SELF PAY RATE.*** *I UNDERSTAND THAT MY INSURANCE WILL NOT BE FILED.*

3. IMPORTANT Attendance Info

WE ARE VERY SERIOUS ABOUT HELPING YOU ACHIEVE YOUR GOALS WHICH MEANS WE ARE VERY SERIOUS ABOUT YOUR ATTENDANCE. WE KINDLY REQUEST THAT YOU ATTEND EACH SESSION AND MAKE SURE YOUR ARRIVE ON TIME AND READY TO GET TO WORK ON YOUR PROBLEM.

We do not want to punish you with fees but we do need timely notification if you cannot attend so that we can offer your appointment to someone else in need. We understand that life situations may arise that affect your ability to attend your appointment **however** *if you provide less than 24 hours' notice of cancellation or if you do not show for your appointment you will be charged.*

The following fees will apply and will be collected before your session:
CANCEL WITH LESS THAN A 24-HOUR NOTICE …….$25
NO SHOW (NOT SHOWING AT ALL OR MORE THAN 15'LATE)…….$50

I HAVE READ AND UNDERSTAND THIS ATTENDANCE POLICY
.

PATIENT/GUARDIAN INITIALS _____

4. How You May Hear From Us

WE USE AUTOMATED APPOINTMENT REMINDERS FOR YOUR APPOINTMENTS. ***PLEASE CHECK THE ONE METHOD YOU PREFER***

o **TEXT MESSAGE** o **VOICE CALL** o **EMAIL**

You may receive messages from us via text or email about your appointment or other important information you may need to know to get the best results for you and your care. If you do not want those messages you can easily opt out within the messages or just let us know at the front desk.

Pre-Exam Pelvic Floor Questionnaire

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

Patient Name: _____ Date of Birth: _____

Date of last pelvic/prostate exam: _____

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

When did this problem start? _____

Did you have surgery for this problem? ☐ No ☐ Yes, When? _____

What procedure? _____

Please list any other previous treatments for this problem: _____

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).

- ❑ Hygiene
- ❑ Dressing
- ❑ Toileting
- ❑ Sleep
- ❑ Household Chores
- ❑ Drive Community Distance
- ❑ Volunteering
- ❑ Squatting
- ❑ Kneeling
- ❑ Sitting
- ❑ Standing
- ❑ Stairs
- ❑ Moving From Bed to Chair
- ❑ Shopping
- ❑ Use of an Assistive Device
- ❑ Walking
- ❑ Kicking
- ❑ Work/Occupation
- ❑ Recreation

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

If you are 65 or older - have you had any falls in the past 12 months? O Yes O No
If Yes, how many falls have you had? _____ Were you injured in the fall(s)? 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 and include if you take by mouth, topically, injection, etc. O I have provided a separate medication list

_____

Please tell us more about your medical history. Please check all that apply:

- ❑ I have no known past medical history to affect treatment
- ❑ Alzheimer's
- ❑ Cardiovascular disease
- ❑ Pacemaker
- ❑ Hypertension
- ❑ Obesity
- ❑ osteoarthritis
- ❑ Stroke
- ❑ Diabetes type 1
- ❑ Diabetes type 2
- ❑ Fibromyalgia
- ❑ Parkinson's
- ❑ Rheumatoid arthritis
- ❑ History of cancer
- ❑ Immunosuppression
- ❑ Lupus
- ❑ Muscular dystrophy
- ❑ Muscular sclerosis
- ❑ Traumatic brain injury
- ❑ Other: _____

Pelvic Pain

Do you have Pain? ☐ No ☐ Yes, Location: _____

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

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.healthyaiken.com

Pre-Exam Pelvic Floor Questionnaire

At worst _____, currently _____, at best _____

Describe your pain further by checking all the applicable descriptions:

- ❑ Burning
- ❑ Sharp
- ❑ Dull / achy
- ❑ Throbbing
- ❑ Shooting
- ❑ Numb / Tingle
- ❑ Constant
- ❑ Intermittent
- ❑ Worse in AM
- ❑ Worse in PM
- ❑ Worse at night
- ❑ Other: _____

This section for WOMEN ONLY:

Are your menstruation cycles regular?	❑ No	❑ Yes	❑ N/A
Do you have pain during menses?	❑ No	❑ Yes	❑ N/A
Are you using birth control?	❑ No	❑ Yes	❑ N/A
Is inserting a tampon painful?	❑ No	❑ Yes	❑ N/A

Have you had any pregnancies? ☐ No ☐ Yes, Number: _____

Vaginal Delivery: _____ Episiotomies: _____ Cesarean Delivery: _____

Bladder Symptoms

How many times do you urinate during the day? _____ During the night? _____

Do you use a form of leakage protection? ☐ No ☐ Adult pad ☐ Mini pad ☐ Liner

Do You Lose Urine When You (check all that apply):

- ❑ Cough/Sneeze
- ❑ On the way to the restroom
- ❑ Hear running water
- ❑ Exercise
- ❑ Jumping/Running
- ❑ Feeling Cold
- ❑ Lifting
- ❑ Laughing
- ❑ During intercourse

Do you:

Wet the bed?	❑ No	❑ Yes
Have burning/pain with urination?	❑ No	❑ Yes
Have difficulty starting a stream of urine?	❑ No	❑ Yes

Bowel Symptoms

How many times a day do you have a bowel movement? _____

What is your most common stool consistency? ☐ Liquid ☐ soft ☐ Firm ☐ Pellets

Do you:

Include fiber in your diet?	❑ No	❑ Yes
Take laxatives/enema regularly?	❑ No	❑ Yes
Have diarrhea often?	❑ No	❑ Yes
Feel you have to wipe the anus excessively to clean yourself?	❑ No	❑ Yes
Have to support the pelvic region or lean your body to evacuate completely?	❑ No	❑ Yes
Have a history of hemorrhoids?	❑ No	❑ Yes
Have a history of anal fissures?	❑ No	❑ Yes

Sexual Activity

Is intercourse painful?	❑ No	❑ Yes	❑ N/A
Is the initial penetration painful?	❑ No	❑ Yes	❑ N/A
Is orgasm painful?	❑ No	❑ Yes	❑ N/A
Do you have pain after sex?	❑ No	❑ Yes	❑ N/A
Do you have a history of sexual abuse?	❑ No	❑ Yes	❑ N/A

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Pre-Exam Pelvic Floor Questionnaire

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. _____

REQUIRED:

❑ **I am bringing a chaperone/partner to my PT visit.**
Relationship of chaperone to you: _____

❑ **I decline having a chaperone / partner accompany me to my PT visit**

_____ _____
Signature (parent/guardian if under 18) Date

OFFICE USE ONLY: ***Height (inches)*** _____ ***Weight (pounds)*** _____
Blood Pressure _____ O *Patient refused height and weight measurement* O *Not Safe to Weigh Patient*

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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*** *(skip to Acknowledgement of Financial Policies).*

O ***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/Company 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. 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.

I authorize the following individuals to have access to my Protected Health Information:_____

_____/_____

Signature of Patient (Required) ***Date***

_____/_____

Signature of Representative (Where Required) ***Date***

Office Use Only:

Initials:_____ Date:_____