



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 _____
- 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

TEXT AND EMAIL WILL HELP US TO SERVE YOU BETTER AND MOST TIMELY BUT WE NEED YOUR PERMISSION (FOR APPOINTMENTS AND OTHER IMPORTANT INFORMATION). **CHECK THIS CIRCLE PLEASE:** → YES, YOU CAN COMMUNICATE WITH ME VIA TEXT AND/OR EMAIL ABOUT MY APPOINTMENTS. I PREFER. TEXT MESSAGE VOICE CALL EMAIL



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/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 (list those you would like for us to release information to about your appointments, payment or other info related to your care.)

Name(s): _____

_____/_____
Signature of Patient (Required) Date

_____/_____
Signature of Representative (Where Required) Date

Office Use Only:

Initials: _____ Date: _____

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? Yes No If yes, when? _____

What procedure? _____

Please list 3 things you are you unable to do or have difficulty doing because of your current problem.

- 1.
- 2.
- 3.

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

Please tell us more about your lifestyle habits. We just want to know more about you because we care about your total health:

How many hours/night do you sleep?

Do you exercise regularly?

Do you have ways and outlets to manage your stress?

Pre-Exam Questionnaire

(Optional) I have one or more of the following bladder leakage, difficulty emptying bladder, pain or burning with urination, difficulty starting or stopping urine stream, urinate more than 2x per night Yes No

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? Yes No

If you are 65 or older - 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

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