# Aptitude Physical Therapy, LLC

**PATIENT INFORMATION** **DATE:**

**Name:** _____
*Last* *First* *M.I.*

**Gender:** ____Male ____Female **Date of Birth:** _____

**Address:** _____
*Street* *City, State* *Zip*

**Phone#:** (_____)_____ **Work/ALT:** (_____)_____ ext: _____

**Email Address:** _____

**Social Security #:** _____ **Marital Status:** Married OR Single OR Other
Patient's (Necessary for Billing)

**Employer or School:** _____

**Employer Address:** _____
*Street* *City, State* *Zip*

**EMERGENCY CONTACT – Name:** _____

**Relationship:** _____ **Phone:** (_____)_____

**RESPONSIBLE PARTY – PARENT OR GUARDIAN OR OTHER – please circle one**

**Name**:_____ **Phone #:** (_____)_____

**Date of Birth:** _____ **Social Security #:** _____

**Address:** _____
*Street* *City, State* *Zip*

**INJURY INFORMATION**

Condition is related to: ___Work ____Auto ____Home ____Sports ____Other ____None

How did you hear about us? _____

Have you had any therapy services in the last 12 months? YES OR NO

If YES, where did you have the services? _____

**Date of injury/onset of condition**: _____Type of injury:_____

Referring Physician: _____

Primary Care Physician:_____

**INSURANCE INFORMATION**

**PRIMARY** Insurance Co.: _____

Ins. Phone #: (_____)_____ (Provider's # is located on the back of the card)

**GROUP #:** _____ **POLICY ID:** _____

**SECONDARY** Insurance Co:_____

Ins. Phone #: (_____)_____ (Provider's # is located on the back of the card)

**GROUP #:** _____ **POLICY ID:** _____

**Please allow the front office 1-2 business days to contact your insurance regarding Physical Therapy benefits and eligibility.**

## AUTHORIZATION FOR DISCLOSURE

I, a patient of Aptitude Physical Therapy, LLC, give my expressed permission to discuss with the individual(s) I have listed:
Please check appropriate box(es):

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name: _____ Relationship: _____Phone:(_____)_____

Name: _____ Relationship: _____Phone:(_____)_____

A confidential message (i.e.: appointment reminders) may be left on your telephone answering machine or voicemail. Please print the telephone number where you want to receive calls about your appointments or other health information other than the phone number listed:

(_____)_____EMAIL:_____

SIGNATURE: _____ Date: _____

## INFORMED CONSENT

I consent to treatment rendered by Aptitude Physical Therapy, LLC in accordance with state statute. I agree to participate in Aptitude Physical Therapy, LLC's program to the best of my ability to facilitate a rapid and full recovery.

I consent to having my picture taken for objective analysis of my condition. This information will be used solely for the purpose of education for myself for my condition and to compare pre and post treatment outcomes. Any other use of this information will require my written consent.

I understand that some increase in pain may be normal. I must determine how much pain increase is acceptable to me, and I may be asked to describe any pain using a Visual or Numeric Pain Scale. I will not be asked to perform activities that increase my pain to a level that is unsafe or undesirable to me. I will be asked to perform activities, but will not be forced to perform any activity that I believe unsafe. I will be informed if I'm seen doing anything unsafe or that jeopardizes my recovery.

## CONSENT FOR RELEASE OF INFORMATION

Insurers may release to Aptitude Physical Therapy, LLC, any information regarding the extent of my insurance coverage, information concerning the status of claims submitted by Aptitude Physical Therapy, LLC, and information regarding payments made directly to me on those claims. Aptitude Physical Therapy, LLC may obtain any information and/or medical records pertinent to "treatment" provided from hospitals, physicians, nursing agencies, and other health care providers, Pursuant to the privacy rule 45CFR164.501 of HIPAA, "treatment" generally means the provision, coordination, or management of health care and related services among providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

## RECEIPT OF PRIVACY PRACTICE NOTICE

I understand that Aptitude Physical Therapy, LLC, has provided me with a copy of their Notice of Privacy Practices, which states how my personal health information (PHI) may be used or disclosed and outlines my rights regarding this information. I understand that Aptitude Physical Therapy, LLC, has the right to change this notice at any time and that I must request in writing any objections to any of these "uses" or "disclosure". I may obtain an additional copy of this notice from this office per my request.

**Please check one of the following statements**:

☐ I received a copy of the Privacy Practices ☐ I declined a copy of the Privacy Practices

## ASSIGNMENT OF BENEFITS

**I understand that I am ultimately responsible for the charges incurred for my services at Aptitude Physical Therapy, LLC, whether or not the benefits are paid through Commercial Insurance, Workers' Compensation or Third-Party Payers (i.e.: auto accident).**

I also understand that additional information may be required of me to assist Aptitude Physical Therapy, LLC, in filing such claims. I **MAY** have to provide information from the following list regardless of my insurance:
**- Social Security Number -Date of Birth -Copy of Insurance Card (for commercial filing and/or workers' compensation) - Name of employer, Employer address, phone number and contact person - Auto Insurance**

**Aptitude Physical Therapy, LLC, will file my insurance claims as a courtesy, and I understand that any quoted benefits given at the time of service are NOT a guarantee of payment. I understand that I am held financially responsible for all co-pays, co-insurances, deductibles, or any additional expenses not covered by the insurance company. I assign all benefits paid by insurance to be paid directly to Aptitude Physical Therapy, LLC. By my signature below I acknowledge my responsibility and assign said benefits and verify that I have read and agree to the terms of the Aptitude Physical Therapy, LLC, Payment Policy.**

| Signature of Patient/Guardian | Date | Front Office Staff Signature |
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