1342 E. Primrose St., Suite A
Springfield, Missouri 65804
info@aptitudept.com
Phone (417) 890-7787
Fax 1(417)890-9397

PATIENT REGISTRATION

Please bring your insurance card(s) and photo ID to your first appointment.

PATIENT INFORMATION

Patient DOB _____/_____/_____ **Today's Date** _____/_____/_____

Patient Name _____
Last Name First Name M.I.

Address _____
Street City, State Zip

Cell Phone Number _____ **Alt. Number** _____

Email address _____

Gender _____Male _____Female **Marital Status** _____Married _____Single _____Other

Employer or School _____

Employer/School Address _____
Street City, State Zip

Have you had any therapy services in the last 12 months? _____Yes _____No

If yes, where did you have the services? _____

Emergency Contact

Name _____ **Relationship** _____ **Phone Number**_____

Aptitude Physical Therapy

Name:_____

Date of Birth:_____/_____/_____

RESPONSIBLE PARTY

Check one _____Self _____Parent/Guardian _____Other

Name _____ **Phone Number** _____

Date of Birth _____/_____/_____ **Social Security Number** _____-_____-_____

Address _____

Street City, State Zip

INJURY INFORMATION

Condition is related to:

_____Work _____Auto _____Home _____Sports _____Other _____None

Date of injury/onset of condition _____/_____/_____ **Type of injury**_____

Referring physician _____

Primary care physician _____

How did you hear about us? _____

Aptitude Physical Therapy

Name:_____

Date of Birth:_____/_____/_____

AUTHORIZATION FOR DISCLOSURE

I, a patient of Aptitude Physical Therapy, LLC, give my expressed permission to discuss the following checked information with the individual(s) I have listed:

Please check your preferences:

_____ Any aspect of my healthcare

_____ 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 may be sent by text, email or left on your telephone answering machine or voicemail. Please print the telephone number and/or email address (that you check regularly) where you want to receive texts, emails or calls about your appointments or other patient information.

Texts _____ **Phone calls** _____

Email _____

_____ _____ _____

Signature of Patient/Guardian Date Front Office Staff Signature

Aptitude Physical Therapy

Name:_____

Date of Birth:_____/_____/_____

INFORMED CONSENT

_____ (Initials) 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.

_____ (Initials) I consent to having my picture taken for objective analysis of my condition. This information will be used to educate myself regarding my condition and to compare pre-/post-treatment outcomes. Any other use of this information will require my written consent.

_____ (Initials) 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 is unsafe. I will be informed if I'm seen doing anything unsafe or that jeopardizes my recovery.

CONSENT FOR RELEASE OF INFORMATION

_____ (Initials) 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 healthcare providers. Pursuant to the privacy rule 45CFR164.501 of HIPAA, "treatment" general means the provision, coordination, or management of healthcare and related services among providers or by a healthcare provider with a third party, consultation between healthcare providers regarding a patient, or the referral of a patient from one healthcare 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

Aptitude Physical Therapy

Name:_____

Date of Birth:_____/_____/_____

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
- Automobile 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, and 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

Aptitude Physical Therapy

Name:_____

Date of Birth:_____/_____/_____

CANCELLATION POLICY

APPOINTMENT DELAYS

Out of consideration for the schedules of our office and all of our patients, we request that patients call if they will be more than **5 minutes late** for an appointment. Once we are notified of a delay, we can try adjusting for the benefit of all patients. If a patient will be more than **15 minutes late**, we may need to reschedule the appointment and charge for the missed appointment.

CANCELLATION NOTICE AND FEE

To cancel appointments, patients must contact the front desk by **4:00 p.m. the prior business day**. Failure to do so will result in a **$65 cancellation fee** on the account that must be paid prior to future physical therapy appointments.

In cases of emergency, illness, or inclement weather; the cancellation fee may be waived at the discretion of the manager at Aptitude Physical Therapy.

I understand the cancellation and delay policy at Aptitude Physical Therapy, LLC, and agree to abide by it.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Date

_____ _____

Front Office Signature Date

Aptitude Physical Therapy

Name:_____

Date of Birth:_____/_____/_____

MEDICAL SCREENING FORM

Reason for today's visit _____ **Date of Onset** _____/_____/_____

Have you had surgery for this injury/condition? Yes / No

Date of next referring PC appointment _____/_____/_____

In the past 3 months, have you experienced:

____ Change(s) in Your Health
____ Nausea / Vomiting
____ Fever / Chills / Sweats
____ Unexplained Weight Change
____ Numbness / Tingling
____ Weakness
____ Change(s) in Appetite
____ Difficulty Swallowing
____ Change(s) in Bowel or Bladder Function
____ Shortness of Breath
____ Dizziness
____ Upper Respiratory Infection
____ Urinary Tract Infection

Do you have a history of:

____ Angina / Chest Pain
____ Biomedical Implants
____ Bronchitis
____ Circulation Problems
____ Heart Disease
____ High Blood Pressure
____ Kidney Disease
____ Stroke
____ Osteoporosis
____ Rheumatoid Arthritis
____ Seizures
____ Allergies / Asthma
____ Blood Clots
____ Cancer
____ Diabetes
____ Headaches
____ Infectious Disease (i.e. TB)
____ Liver Disease
____ Osteoarthritis
____ Rheumatic Fever
____ STI's
____ Ulcers

Do you have a family history of:

____ Cancer
____ Diabetes
____ High Blood Pressure
____ Heart Disease
____ Angina / Chest Pain
____ Stroke
____ Osteoporosis
____ Osteoarthritis
____ Rheumatoid Arthritis

Aptitude Physical Therapy

Name:_____

Date of Birth:_____/_____/_____

Are you currently: ____Pregnant ____Depressed ___ Anxious ____Under Stress

Are you allergic to latex? Yes / No

Are your symptoms: ____Getting Worse ____Same ____Improving

How are you able to sleep at night: ____Fine ____Moderate Difficulty ____Only with Medication

Do you have a problem with:____Hearing ____Vision ____Speech ____Communication

Do you have or have you in the past smoked tobacco: Yes / No
If yes, ____packs per day for ____years Last date of tobacco use _____/_____/_____

Do you drink alcoholic beverages routinely? Yes / No If yes, ____ beverages per week

When was your last physical examination: _____/_____/_____

Is there any other information that would assist us with your care?

_____

Is there anything else related to your health that we have not asked for?

_____

List Medications currently taking:

_____

_____

_____

_____

_____

List current healthcare providers:

_____

_____

_____

Patient or Guardian Signature: _____ **Date:** _____/_____/_____

Therapist Signature: _____ **Date:** _____/_____/_____

Aptitude Physical Therapy

Name:_____

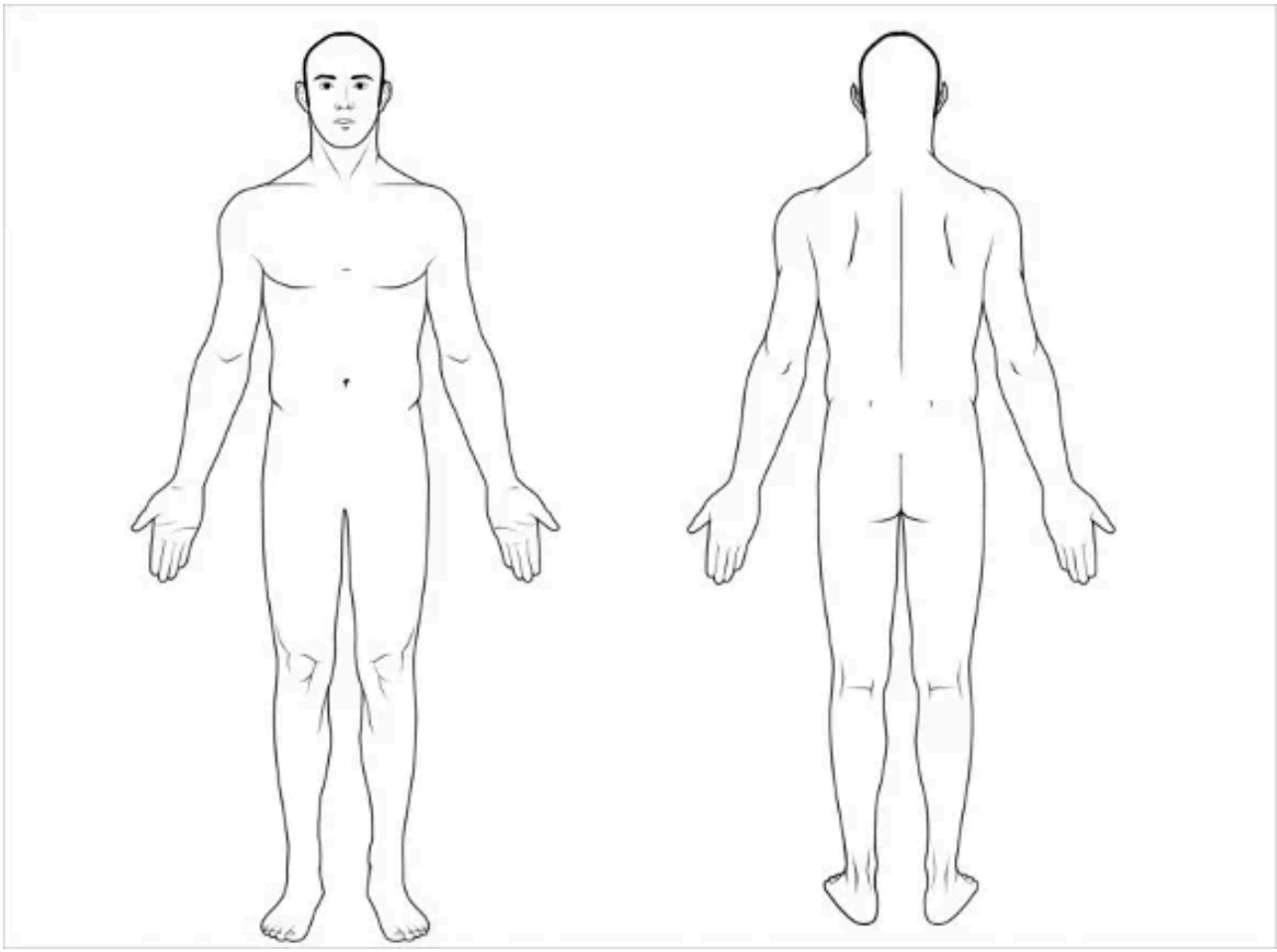
Date of Birth:_____/_____/_____

Body Diagram

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY:

Pins & Needles = 00000
Burning = XXXXX
Stabbing = ////////
Deep Ache = ZZZZZ



	No Pain									Emergency
Pain now:	0	1	2	3	4	5	6	7	8	9	10
Worst pain last week:	0	1	2	3	4	5	6	7	8	9	10
Best pain last week:	0	1	2	3	4	5	6	7	8	9	10

Aptitude Physical Therapy

Name:_____

Date of Birth:_____/_____/_____

The Patient-Specific Functional Scale

This useful questionnaire can be used to quantify activity limitation and measure functional outcome for patients with any orthopedic, neurologic, or cardiopulmonary condition. This will also help establish patient-specific goals for your treatment.

Identify up to THREE important activities that you are unable to do or are having difficulty with as a result of your injury/problem.

Patient-Specific Activity Scoring Scheme (Score each activity 0-10):

0 1 2 3 4 5 6 7 8 9 10

0 = unable to perform activity

10 = able to perform activity as before injury without pain

ACTIVITY	**DATE:** ____/____/____	**DATE:** ____/____/____	**DATE:** ____/____/____	**DATE:** ____/____/____	**Score, Date & Initial (Completed by Phys. Therapist)**
1.	**Score 1-10**	**Score 1-10**	**Score 1-10**	**Score 1-10**	
2.	**Score 1-10**	**Score 1-10**	**Score 1-10**	**Score 1-10**	
3.	**Score 1-10**	**Score 1-10**	**Score 1-10**	**Score 1-10**	
Additional:	**Score 1-10**	**Score 1-10**	**Score 1-10**	**Score 1-10**	
Additional:	**Score 1-10**	**Score 1-10**	**Score 1-10**	**Score 1-10**	

PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change of individual patients: a report of a patient-specific measure. Physiotherapy Canada, 47, 258-263. Reproduced with the permission of the authors.