Aptitude Physical Therapy, LLC

PATIENT INFORMATION **DATE:**

Name: _____ **Sex:** ____Male ____Female
Last First M.I.

Address: _____
Street City, State Zip

Home Phone: (____)_____ **Work:** (____)_____ ext: ____ **Cell:** (____)_____

Email Address: _____

Social Security #: _____ **Date of Birth:** _____ **Marital Status:** __Married
Patient's (Necessary for Billing) __Single __Other

Employer or School: _____

Employer Address: _____
Street City, State Zip

EMERGENCY CONTACT – Name: _____

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

RESPONSIBLE PARTY

Name (Patient/Guardian/Other, who brought minor for therapy): _____

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

Address: _____
Street City, State Zip

Home Phone: (____)_____ **Work:** (____)_____ ext: ____ **Cell:** (____)_____

INJURY INFORMATION

Condition is related to: ___Work ____Auto ____Home ____Sports ____Other ____None

Is a home health agency currently providing nursing/PT services in your home? ____Yes ____No

How did you hear about us? _____

Have you had any therapy services in the last 12 months? ____Yes ____No

If YES, where did you have the services? _____

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

Referring Physician: _____ Referring Physician's NPI#: _____
(to be completed by the Front Office)

Primary Care Physician: _____

Name: _____ Date: _____

INSURANCE INFORMATION

Primary Insurance Co.: _____ Ins. Phone #: (____)_____

Group #: _____ **Policy I.D. #:** _____

Is the patient the subscriber? ____Yes ____ No If **NO, then:**

Subscriber/Policyholder's Name: _____ Phone #: (____)_____

Subscriber/Policyholder's Address: _____
Street *City,State* *Zip*

Relationship to Patient: _____ Subscriber/Policyholder's Date of Birth: _____

Subscriber/Policyholder's Social Security #: _____

Subscriber/Policyholder's Employer & Employer's Address: _____

_____

Secondary Insurance Co.: _____

Group #: _____ **Policy I.D. #:** _____

Is patient the subscriber? ____Yes ____No If **No, then:**

Subscriber's Name: _____ Relationship to patient: _____

Subscriber's Employer: _____ Subscriber's Date of Birth: _____

Employer's Address: _____ Subscriber's Social Security #: _____

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 your home phone:
(_____)_____

Name: _____ 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 of 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 the benefits are through Commercial Insurance, Workers' Compensation or a 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 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** **Witness**