AID Performance Physical Therapy
44025 Pipeline Plaza, Suite 200, Ashburn, VA 20147
703-723-6758 www.aidperformancept.com

Non-Medicare - PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: ______________________ DOB: __________ Age:__ Sex: ______

SSN: ______________ Home #:__________ Work#:__________ Cell:__________

Address:______________________ City:__________ State:____ Zip:______

Email: ______________________

Responsible Party: ______________________

Primary Physician: ______________________ Office#:______________

Referring Physician: ______________________ Office#:______________

Employer: ______________________

Employer Address:______________________________________

How Did You Hear About Us: 1. Friends/Family 2. Phone Book 3. Health Insurance 4. Internet 5. Outside Physician

INSURANCE INFORMATION

Primary Insurance:______________________________________

Subscriber: ______________________ DOB:__________ SSN:__________

Policy:______________ Group:__________ Employer:__________

Relationship to Patient:______________ Effective Date:______________

Secondary Insurance (if applicable):______________________________

Subscriber: ______________________ DOB:__________ SSN: __________

Policy:______________ Group:__________ Employer:__________

Relationship to Patient:______________ Effective Date:______________

EMERGENCY CONTACT INFORMATION

Name: ______________________ Relationship to Patient: __________

Home #: ______________ Work #: ______________ Cell: ______________

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical (physical therapy) benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to AID Performance Physical Therapy, LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Signature: Patient / Guardian / Responsible Party ____________________________________ Date ____________________
(Please circle)

FINANCIAL POLICY STATEMENT

You are responsible for the entire balance of your bill. As a courtesy however, we will bill your insurance carrier. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If your account is past due over 30 days, we reserve the right to charge the credit card on file for the remaining balance at that time. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining. If any payment is made directly to you for services rendered by us, you recognize an obligation to promptly remit same to AID Performance Physical Therapy, LLC.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be responsible for the total amount of charges for services rendered to you. You understand and agree that if you fail to make any of the payments for which you are responsible for in a timely manner, you will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS:

____

ARRANGEMENT FOR PAYMENT OF PATIENTS SHARE:

____

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

INFORMATION PRIVACY

AID Performance Physical Therapy, LLC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and/or have copies available for distribution. The undersigned acknowledges receipt of this information.

CANCELLATION POLICY/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for treatment, due to a seemingly "full" appointment book.
If an appointment is not cancelled at least 24 hours in advance, you personally will be charged a $35.00 cancellation fee (not your insurance company). If you should fail to show or call, you will be charged a $50.00 no-show fee. This fee must be paid prior to your next scheduled appointment time. Failure to comply may result in forfeiture of future appointments until the fee is satisfied. If you do not show up for three consecutive appointments, you will be discharged from physical therapy and you must visit your doctor for a new prescription prior to your next physical therapy visit.

LATE SHOW POLICY

Any patient arriving 15 minutes late will only be treated for the remainder of their scheduled appointment time. Patients arriving 20 minutes late will be asked to reschedule their appointments.

NSF RETURNED CHECK IS $50.00

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

Signature: Patient / Guardian / Responsible Party ______________________________________ Date __________________
(Please circle)

____ Date __________________

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for AID Performance Physical Therapy, LLC to furnish medical care and treatment to ______________________________ as considered necessary and proper in diagnosing or treating his/her physical condition. (Print Patient's Name)

I consent to rehabilitation and related services with **AID Performance Physical Therapy**. In so doing, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature.

I am participating in physical activity at **AID Performance Physical Therapy.** I recognize that any physical activity may be strenuous and may cause injury, and I am fully aware of the risks and hazards involved in such activity.

In consideration of being permitted to participate in these treatments, I agree to assume full responsibility for any risks, injuries, or damage, known or unknown, which I might incur as a result of participation in these activities or as a result of negligence.

Initial Below:

____I hereby give permission for myself/my child to participate in activities using the equipment at **AID Performance Physical Therapy**. I understand that I may be injured as a result of my negligence, or through no fault of myself or anyone else, because of the nature of the activity in which I am going to be engaged.

____I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

____I agree to comply with all the posted rules and regulations for the equipment at **AID Performance Physical Therapy**.

I hereby release, discharge, and acquit **AID Performance Physical Therapy**, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, emergency medical technician, physician, or urgent care services

I know and agree that **AID Performance Physical Therapy** is not responsible for loss or damage to personal valuables.

I have carefully read this participant agreement and fully understand its terms.

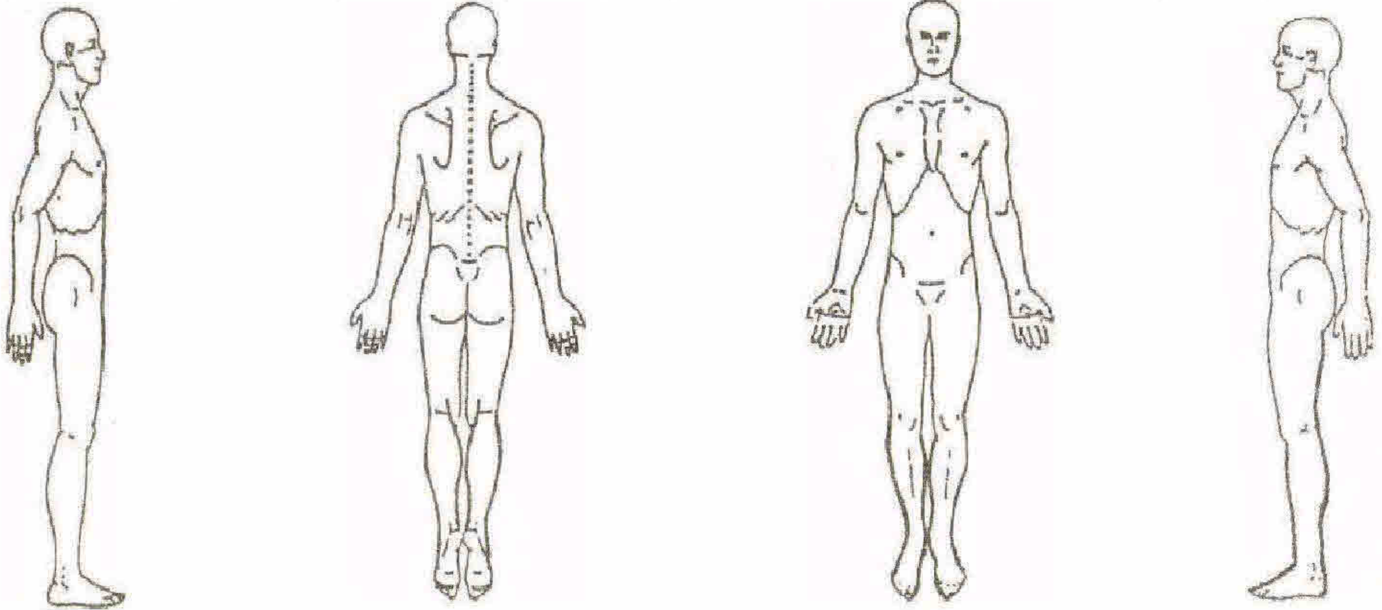
Participant/Parent's Signature________________________________ **Date:** ____/____/____

PAIN ASSESSMENT FORM

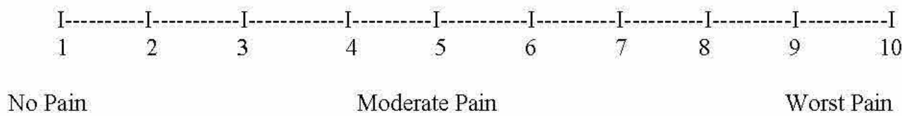
1. Describe the nature of your Problem: ____

   Pain Drawing: Use the symbols below to mark the areas on your body where you feel the following sensations:

Aching	Burning	Numbness	Pins and Needles	Stabbing
V	X	0	=	/



Please indicate your CURRENT pain level on the chart below:



2. What if any treatments have you had for this current problem? ________________________
3. Did they help? YES_____ NO_____
4. What in particular makes your pain worse? ____
5. What makes your pain better?____
6. Can you get comfortable at night? YES_____ NO_____
7. How do you feel upon rising? Stiff___ Sore___ Fine____
8. Once you start moving about, does it worsen_____ ease_____?
9. What is it like at the end of the day? Worse______ Easier______
10. Do you have any pins and needles, etc? YES___NO____(If yes, please indicate location on the diagram above)
11. At this time, do you consider you are getting better___, worse___, or stable___?

Patient Name (please print):____

Patient Signature____

Date__________________________

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

NAME: ______________________________ **LEISURE ACTIVITIES**_______

OCCUPATION:_____________________________________

ALLERGIES: List any medication(s) you are allergic to:____

Are you latex sensitive? Yes No List any other allergies we should know about ___________________________

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes **No**

Please check (1-4) any of the following whose care you're under

___ Medical doctor (MD: ___ Psychiatrist/Psychologist Other____
___ Osteopath ___ Physical 'Therapist
___ Dentist ___ Chiropractor

Date of last physical examination ______________________________

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer. If YES what kind
YES NO Heart Problems. If YES what kind
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Stomach ulcers
YES NO Chemical dependency (i.e., alcoholism)
YES NO Thyroid problem
YES NO Diabetes
YES NO Multiple Sclerosis
YES. NO Rheumatoid arthritis
YES NO Other arthritic conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease if YES what kind
YES NO Blood clots
YES NO Osteoporosis
YES NO Other

For Office Use

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

SURGERIES/HOSPITALIZATIONS (INCLUDE DATE AND REASON)

1.____**2.**____

3. ____**4.**____

5. ____**6.**____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
________	________________________	________	____________________
________	________________________	________	____________________

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES NO Diabetes
YES NO Heart disease
YES NO High blood pressure
YES NO Stroke
YES NO Inflammatory Arthritis (Rheumatoid, Ankylosing)
YES NO Cancer
YES NO Alcoholism (chemical dependency)
YES NO Depression
YES NO Kidney disease

Which of the following medications have you taken in the last week?

	Physician Prescribed	Not Prescribed by Physician
Aspirin	YES/NO	YES/NO
Tylenol	YES/NO	YES/NO
Anti-inflammatories(Advil/Motrin/Ibuprofen/Aleve,etc)	YES/NO	YES/NO
Stomach ulcer medications	YES/NO	YES/NO
Vitamins/mineral supplements	YES/NO	YES/NO
Herbals/Remedies	YES/NO	YES/NO

Others NOT prescribed by a physician __________________________

Please list any other physician-prescribed medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. ______________________ 2.__________________________ 3. ____________________________

4. _____________________ 5.__________________________ 6. _____________________________

How much caffeinated coffee or caffeine containing beverages do you drink per day?

Tobacco use: How many packs do you smoke per day ____ for how many years _______ If quit when? _________

How many days per week do you drink alcohol? _______

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _________

Have you recently noted:

YES NO weight loss/gain
YES NO nausea/vomiting
YES NO dizziness/lightheadedness
YES NO fatigue
YES NO fever / chills/ sweats
YES NO numbness or tingling
YES NO tremors
YES NO seizures
YES NO double vision
YES NO loss of vision
YES NO eye redness
YES NO Skin rash
YES NO problems sleeping
YES NO sexual difficulties
YES NO night sweats
YES NO hearing problems
YES NO weakness
YES NO joint/muscle swelling
YES NO easy bruising
YES NO excessive bleeding
YES NO difficulty breathing
YES NO regular cough
YES NO arm/leg swelling
YES NO heart racing in your chest
YES NO difficulty swallowing
YES NO heartburn/indigestion
YES NO constipation/diarrhea
YES NO blood in stool
YES NO post menopause
YES NO problems urinating (difficulty starting, painful etc.)
YES NO urinary incontinence
YES NO blood in the urine
YES NO pregnant or think you might be pregnant
YES NO stress at home or work

Therapist signature: ___________________________Date: ________Patient signature: ________________________________Date:________