Aquatic Physical Therapy & Beyond, LLC Patient Medical History

Name: ____________________________________ Date:__________________

Do you presently have or have you previously had heart problems? _____Yes ____No

If yes, check all that apply.

- ❑ Heart Attack
  - o How Many? _____ When? ______________________________
- ❑ Chest Pain
- ❑ Congestive Heart Failure
- ❑ Abnormal Heart Rate

  _______Fast _______Slow ______Irregular
- ❑ Pacemaker
- ❑ Heart Surgery
  - o Angioplasty (Balloon) When? ______________________
  - o By-Pass When? ______________________
  - o Other______________ When? ______________________
- ❑ Other Heart Problems____

If you presently have or have previously had any of the following conditions, check all that apply.

- ❑ Asthma
- ❑ Emphysema
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Shortness of Breath
- ❑ Other Breathing Problems____
- ❑ Circulatory Problems____
- ❑ Seizures
- ❑ Stroke
- ❑ Back or Neck Problems
  - o Type____
  - o Surgeries and Dates ______________________________________
- ❑ Other Orthopedic Problems
  - o Type ____
- ❑ Surgeries and Dates ____
- ❑ Cancer
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Degenerative Joint Disease (DJD)/Osteoarthitis
- ❑ Rheumatoid Arthritis
- ❑ Pregnancy (currently)
- ❑ Recent Surgeries not mentioned above

  Type_______________________ Date_______________

  Are you allergic to any drugs/medications? If so, which ones?

  ____

  What medications are you currently taking?

  ____

  ____

Physical Therapist Signature: ______________________________ Patient Signature: __________________________

If you use an inhaler, take Nitroglycerine tablets or any other emergency medication please bring it with you to each appt & let your treating therapist know where it is.

Pool and Spa Questionnaire

1. Are you taking any antibiotics, have any infections or running a fever at this time?
___Yes ___No If yes, please list and describe: ____

____

2. Do you have bowel or bladder problems? (example: dribbling, unable to control bowel or bladder? Yes No _______ If yes, please explain: ____

____

3. Do you have any wounds or open skin areas? ___Yes ___No If yes, please describe:

____

4. Do you have any bandages or dressings at this time? ___Yes ___No If yes, where are they located and why are they there?____

____

5. Do you have any tubes? (Example: feeding tube, catheter, GI tube) ___Yes ___No
If yes please explain: ____

6. Do you have any rashes? ___Yes ___No If yes, please describe: ___________________________

____

7. Do you have normal blood pressure? ___Yes ___ No If No, please explain:

____

PLEASE NOTE: If during the course of your therapy, you develop ANY of these symptoms, YOU MUST let your therapist know BEFORE you enter the pool/hot tub. It is URGENT that these symptoms be addressed before you enter the pool for your safety as well as the other patient's.

To get Ready for the Pool:
____ I will bring my own help for changing.
____ I do not need help changing.

Swim or Float:
____ I can swim.
____ I don't swim, but I like water.
____ I don't like water, but I'm willing to try.
____ I want a therapist in the pool with me.

Water Chemistry:
____ I have never reacted to chlorine before.
____ I am allergic to chlorine

To enter the pool:
____ I need the chair lift.
____ I need help with the stairs.
____ I can enter the pool on my own

History:
____ I have been in a pool before.
____ I have never been in a pool.
____ I have been in a hot tub before.
____ I have never been in a Hot Tub.

Hot Tub Heat- 100+ temperature
____ I am fine with heat
____ I don' t do well with heat

I have read and understand this form. I agree to abide by the rules of the pool usage. I have been given the opportunity to ask questions and understand that I may ask questions at any time if I am not sure about something.

Patient Signature: ___________________________ Date: ____________

Aquatic Physical Therapy & Beyond, LLC

BE SURE TO WRITE CLEARLY OR YOUR INSURANCE MAY NOT COVER DUE TO INCORRECT INFORMATION! THANKS! ☺

Patient Information

Last Name (Required)	First Name (required)	MI	Nick Name	Sex (M, F)	Date of Birth

Street Address / Apt.#	City	State	Zip

Social Security # if Workers Comp or Military	Home Phone (required)	Work Phone (Required)	Cell Phone (Required)

Name of 1st Insurance	Name of 2nd Insurance (if applicable)	Name of 3rd Insurance & any others (if applicable)

Email Address (Required)	Referring Doctor First and Last Name plus Phone Number if available

Marital Status	Employment	ARE YOU THE POLICY HOLDER ON **ALL** OF YOUR INSURANCES:	IF **NO**, BE SURE TO COMPLETE THE SECTION BELOW MARKED WITH A ✦
☐ M-Married ☐ W-Widowed ☐ S-Single ☐ D-Divorced ☐ X-Separated	☐ R-Retired ☐ F-Full ☐ P-Part ☐ N-None	☐ **YES or NO** →	

If a current or former patient referred you to our facility, please give us their first and last name. Thanks.

REFERRED BY PATIENT: **First Name:** **Last Name:**

Emergency Contact (REQUIRED)

Name of Person in case of an Emergency	Relationship to Patient
Telephone #	Preferred Hospital if any

✦ COMPLETE NEXT SECTION IF YOU ARE NOT THE POLICY HOLDER: ✦

Parent Or Spouse's Information (ALL INFORMATION BELOW REQUIRED IF APPLICABLE)

Title	Last Name	First Name	MI
Date of Birth (**REQUIRED**)	Sex (Male / Female)	Relationship to Patient:	

ACCIDENT DETAILS- Please complete if visit is due to injury

Employment related:	Accident Related:	Date of first symptom or accident:	State Injury took Place
☐ Yes ☐ No	☐ Auto ☐ Other ☐ No		

Give Details of Accident:

By signing below, I authorize the release of any medical or other information necessary to obtain payment from my insurance company or any other third party that is liable for payment for services rendered. I hereby authorize and direct my insurance company or companies, attorney or any other entity financially covering my treatment at Aquatic Physical Therapy & Beyond, LLC to make direct payment to Aquatic Physical Therapy & Beyond, LLC under any and all applicable coverage, including major medical, for covered charges for services rendered. I AUTHORIZE AQUATIC PHYSICAL THERAPY & BEYOND, LLC TO COMPLAIN TO MY INSURANCE(S) COMPANY AND/OR THE INSURANCE COMMISSION ON MY BEHALF. I also authorize the use of my medical information for managing my health care as well as any related services. In addition, I authorize the use of my medical information for the practice's health care operations for the purposes of management or administration of the practice and of offering quality health care services. By signing below I am confirming that I have been given a detailed summary of the NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION.

______________________________ **Patient Signature** ______________ **Date**

Aquatic Physical Therapy & Beyond, LLC

HIPAA Compliance Policy & Procedures

I hereby authorize the following parties to request and receive any protected health information regarding my treatment, including medical records, appointment times and any other information regarding my treatment at Aquatic Physical Therapy & Beyond, LLC.

Note* **Please list any attorneys, siblings, doctors that you do not have a prescription for physical therapy from and any other individuals that will or may need access to your records. Thanks.**

Authorized Designees:

Name:______________________ Relationship:________________ Phone#: _______________

Name:______________________ Relationship:________________ Phone#: _______________

Name:______________________ Relationship:________________ Phone#: _______________

Name:______________________ Relationship:________________ Phone#: _______________

Name:______________________ Relationship:________________ Phone#: _______________

Name:______________________ Relationship:________________ Phone#: _______________

____
Patient Name (print)

____
Patient Signature

____
Date

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Patient Cancellation/No Show Policy

Patients are required to cancel their appointments at least **24 hours in advance**. The 24 hours advanced notice is to be given according to business calendar days, meaning you are required to cancel before the hour of your set appointment time, **One Business** (Monday thru Friday) day in advance.

Example 1: If you possess a Wednesday 2pm appointment, you are required to notify Aquatic Physical Therapy and Beyond by 2pm Tuesday.

Example 2: If you possess a Monday 2pm appointment, you are required to notify Aquatic Physical Therapy and Beyond by 2pm the previous Friday.

If an appointment is canceled **4 hours or less in advance**, there will be a $35.00 no show/cancellation fee administered to their account, to be paid by the patient and not covered by their insurance

Chronic Lateness: If you are late by 10 minutes 3 or more times, you will be liable for a $20 late fee for each additional visit you are tardy by 10 minutes or more.

No Shows: If you no-show for 3 or more appointments, we have the right, at our sole discretion, to take you off of our schedule. If you call to get back on our schedule, it is our discretion as to whether we wish to treat you any further.

If an appointment is canceled with **less than 24 hours but more than 4 hours in advance**, there will be a $35.00 no show/cancellation fee administered to their account, to be paid by the patient and not covered by their insurance. Unless, the patient schedules a make up appointment within seven (7) contiguous calendar days from the day of the missed appointment, in addition to their other prescribed appointments as determined by their therapist and does not cancel any of their already set appointments, then the no-show penalty will be waived.

The physician or the workers compensation coordinator that referred the patient to our office will be notified if the patient fails to show for appointments or is frequently non-compliant with their appointments.

If the above guidelines are not abided by, then we reserve the right to refer you out to another facility with a two (2) weeks notice.

At Aquatic Physical Therapy & Beyond, we pride ourselves on quality, direct patient care and want to assist you in maximizing your rehabilitation potential, but cannot do so if patients do not show for their scheduled appointments, on time and dressed for the proper environment. Thank you so much for understanding.

By signing below, you are confirming that you understand all of the parameters of this policy, all of your questions have been answered and you agree to the terms of this policy. .

______________________________ ____________________
Patient Name (printed) Date

____
Patient Signature

Aquatic Physical Therapy & Beyond, LLC Financial Policy

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The patient needs to know their benefits because we will call to verify them, but the insurance company states when we call, that it is not a guarantee of payment and if we are informed incorrectly and you utilize more visits than your benefits permit, they will not pay and you will be liable. Many insurances count physical, speech and occupational therapy and/or a chiropractor as the same and therefore all or even some of them may deduct from the total visits you are permitted in a fiscal year of your insurance. Call your insurance if you are not sure of your benefits. The phone number will be on your insurance card.

It is the patient's responsibility to present all up-to-date insurance information to the staff at Aquatic Physical Therapy & Beyond, LLC, so that proper verification of coverage can be performed previous to treatment. If the patient does not disclose all pertinent details regarding the coverage provided by their insurance company or any other 3rd party and Aquatic Physical Therapy & Beyond, LLC has any charges rejected, the patient will be liable for all payments and is required to make payment within 30 calendar days from time of rejection.

Most major insurances are accepted. Our Insurance Coordinator will verify the benefits covered for the patient by their insurance company. The Insurance coordinator will explain the patient's co-pay or co-insurance that will be due at the time of service. It is the patient's responsibility to understand their insurance benefits and to disclose all pertinent details with the Insurance Coordinator.

If we participate with the patient's insurance carrier, we will accept the contracted amount for services, except in scenarios reflected in paragraph six (6) below. Patient is still responsible for his/her patient co-pay or co-insurance. Any non-covered service that the care givers feel would be beneficial for the patient will be discussed with the patient previous to application of such treatment to ensure that the patient concurs with such treatment and associated charges. Any non-covered services will be entirely the patient's responsibility and will be due at the time of service.

Whether or not we are a participating provider with the patient's insurance company and the patient fails to provide any necessary information needed for processing the claim, or in any way inhibits payment from his/her insurance company, the patient is then responsible for all of the charges with no discount applied.

Whether or not we are a participating provider with the patient's insurance company, if we bill your insurance company and at any time it is determined another party is expected to cover your physical therapy, i.e. you obtain an attorney and sue someone, you are in an accident and your med pay and the guilty parties insurance is to cover your physical therapy or any other situation of the sort, then we will bill the responsible party for all of our charges and refund the payments your insurance company has issued for our services, unless those reimbursements to the insurance company(s) are already included in your settlement, which in said scenario, the total amount due will be the total billed charges, minus all insurance and guarantor payments.

The patient is required to give all applicable information in order for Aquatic Physical Therapy & Beyond to obtain payment from the responsible party. If the responsible party fails to issue payment for any reason, at that point in time we will go through the patient's insurance company to obtain payment. If the patient's insurance company does not pay for the services rendered, then the patient is liable for all charges.

The patient is ultimately responsible for the charges applied to their account due to services provided to them from Aquatic Physical Therapy & Beyond, LLC. We will bill the insurance company directly. The patient will pay their co-pays that they are liable for in full on a weekly or per visit basis. If it is found that you have a delinquent balance and reasonable attempts to collect have been made, we will utilize the information we have on file to retrieve the funds due to the clinic. This includes the use of your credit card information, bank information and any other information on file needed to obtain payment that is due to the company.

OUT OF NETWORK & OTHER THIRD PARTY INSURANCES: Auto, Business Liability, Legal Arbitration, etc.

In addition to any applicable conditions above, we will bill the respective party that is liable for your damages or whoever is financially covering your physical therapy at Aquatic Physical Therapy & Beyond, LLC. if for any reason payment is sent to you from your insurance, rather than being sent to Aquatic Physical Therapy & Beyond, LLC for services rendered, the check(s) are required to be forwarded to Aquatic Physical Therapy & Beyond, LLC within seventy two (72) hours with your signature on the back & pay to the order of Aquatic Physical Therapy & Beyond, LLC written underneath your signature. The Explanation of Benefits reflecting what dates of service and charges the payment applies to and any other documents sent with the check(s) are to be forwarded to Aquatic Physical Therapy & Beyond along with the check(s). If you do not forward said payments & Explanation of Benefits within 72 hours, you will be held liable for all of the charges for the dates of service that we do not receive payment and/or explanation for, not just the amount that your insurance sent to you.

By signing below you are stating that you have fully read and understand all the circumstances and terminology of the above agreement. In addition, by signing below you are asserting that all questions that you possess have been answered in such as way that you fully understand this agreement.

Patient Name: ______________________________ Date: ____________

Patient Signature: ______________________________

POOL & SPA RULES

1. PLEASE BE CAREFUL WHEN WALKING IN BATHROOM OR POOL AREA BECAUSE THE FLOOR MAY BE WET AT TIMES MAKING IT MORE SLIPERY!
2. If using a cane or other such assistive device for walking, be sure to be very careful in the pool and bathroom area because items such as canes may slip much easier due to the wet floor resulting in a fall. We suggest and encourage the use of a walker, which is available upon request. Walkers are very stable in the bathroom and pool areas. Therefore, if there is any chance that you may fall due to such an instance, be sure to request a walker from the front desk.
3. Please bring your towel with you into the pool area to dry off immediately after getting out of the pool and/or whirlpool. Thanks.
4. Do not get into the water until your therapist is present.
5. You must use any ambulatory aides (crutches, walker, or cane) in the pool area if you use them regularly to walk.
6. Do not run in the pool-room, clinic or restroom areas.
7. You must wear shoes or flip-flops in the pool-room, please leave them at the bottom of the stairs.
8. You must bring in any emergency medicine that you could require, such as inhalers, diabetic medicine, and nitroglycerin.
9. Patients should not submerge themselves fully into the pool, please do not allow your head to go under the water.
10. Do not allow arms, hands, legs or feet to rest behind the corner bars in the pool. (Between the bars and the pool wall.)
11. Horse-playing in the pool-room is not allowed.
12. When using the chair lift- the seat belt must be used.
13. Respect for other people in the pool-room is expected from all persons.
14. Excessive splashing is not allowed in the pool.
15. Pool shoes can be worn into the pool, but not regular street shoes.
16. The sides of the pool are not for sitting, standing or climbing on, please do not attempt to use them for these purposes.
17. The Aquatic Physical Therapy & Beyond staff will adjust the treadmill speed for you- please do not attempt this yourself.
18. Please do not enter the pool if you have open sores. Consult with the staff first.
19. Please do not enter the pool if you have a respiratory infection.
20. Please do not enter the pool if you feel "funny or dizzy".
21. Please do not enter the pool if you are menstruating without proper protection.
22. If at any time you are uncomfortable or have questions or concerns, please let any member of the staff know.

I have read the pool rules and I understand them.

Patient Initials: ________________

Date: ________________________

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Patient Responsibilities

We provide the best physical therapy in the triangle region. We are only able to do this if our patients agree to and comply with the below patient responsibilities:

1) **You agree to show up on time, dressed for the right environment (gym/pool) and at the right hour.**

   When you are late, show for the wrong environment or come at the wrong hour, we are forced to handle a patient load that we did not anticipate. This hurts not only your care, but other patients' care as well. First of all, you don't receive the direct care we anticipated giving you. Secondly, the other patients who are here when you show up do not get the direct care that they were scheduled for. Lastly, we stress trying to give everyone the same excellent service despite the difficult circumstances.

2) **You agree to comply with your treatment plan as prescribed by your physical therapist, including:**

   a. **Showing up for all of your visits each week**
   b. **Showing up ready for the right environment.**
   c. **Performing your home exercises as prescribed to you.**
   d. **Performing &/or adjusting any other daily or nightly activities that you are asked to alter.**

   We have had amazing success with our patients due to the fact that they comply with their treatment plan, show for their visits and come ready for the right environment. If you have any concerns, time or financial restrictions, please bring them to our attention, so that we can figure out how to handle the situation. We will work with you to help you integrate physical therapy into your life's schedule, so that we can resolve your issue.

The front office is only responsible for collecting moneys due to the clinic and scheduling the patients as instructed to do so by the caregivers on your checkout sheet. They cannot change treatment plans, including the number of visits per week that you attend, the number of weeks planned for your treatment or even the environments that you are to be treated in for each visit. All such questions must be directed to your caregivers. If you are forced to cancel one of your prescribed visits and you are not able to set a makeup for a different day of that week, it is your responsibility to relay this to your <u>CAREGIVER</u> as well as the front office.

By signing below, you are stating that all your questions have been answered, so that you completely understand what is expected of you during your treatment at our facility. By signing below you are also declaring that you understand that your physical therapist may conclude your treatment at our facility at any point in time if you do not comply with all the responsibilities enveloped within this agreement.

_______________________________________   ____________________

Patient Printed Name   Date

____

Signature