Aqua Therapy Clinics

Patient Name: _____ **Insured's Name**: _____

DOB: _____/_____/_____ **Age:** _____ **DOB**: _____/_____/_____

Home Address: _____ **Insurance Address**: _____

City _____ State_____ Zip_____ **Phone #**:_____

Patient's Best Phone #:_____ **ID #**:_____

Email address:_____ **Group #**: _____

Occupation: _____ **Last Date Worked:** _____

Activity Level: _____ General Health (check one) ___Excellent ___Good ___Fair ___Poor

Chief Complaint: _____ **Date of Onset:** _____

Medical History List any problems, accidents, illnesses, injuries, surgeries or hospitalization? _____

_____

_____

Sleep Quality: _____ **Sleep Position:** _____

Goals Functionally: _____

Goals with PT: _____

Have you had Physical Therapy previously? ___Yes ___No In the past year? ___Yes ___No When? _____

Previous / Concurrent treatment: _____

What aggravate/increases pain: _____

What relieves /decreases pain: _____

Prescription Medications and Over the Counter: _____

_____

Type of Onset: ____ Gradual ____ Sudden Current Pain? ____Yes ____No **Level:** 1 2 3 4 5 6 7 8 9 10

Comments: _____

_____

_____

Aqua Therapy Clinics

INFORMED CONSENT

STATEMENT

I give AQUA THERAPY CLINICS, permission to:

Use my address, email, phone number and clinical records to contact me with notifications, celebratory cards, special offers, information about treatment alternatives, or other health related information.

Provide therapeutic services to me on a medical basis.

Contact me by phone, and to leave a message on my answering machine or voicemail.

I understand and I am informed that there are some risks associated with (flotation) therapy…

Salt stings, irritates and/or burns if it gets into the eyes, open scratches or wounds or IF you have a rash or unusually sensitive skin

I will float on my back, not stomach or sides at all times or risk drowning

I should consult my doctor if I am on any medication prior to floating and will not float if I am under the influence of drugs or alcohol

I should not float if I have any open or bleeding wounds

I should not float if I suffer from incontinence, nausea or epilepsy

- *There is a $500 or more, clean up fee, if I contaminate the pod in any way!*

Other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak at any time in private, a room will be provided for these conversations.

I am physically capable of entering and exiting the float pod on my own. I agree that I am capable of rising from a recumbent position without assistance. I understand that Aqua Therapy Clinics (Arizona Therapeutic Wellness Centers, LLC) are not responsible for any injury caused by falling or slipping.

I, hereby direct that AQUA THERAPY CLINICS shall submit any billing data or related claim(s) for, or on, my behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom I have insurance coverage and I have been provided with physical therapy treatments that are billable under insurance. I hereby acknowledge that I will be financially responsible to remit payment in full for all services provided to me at AQUA THERAPY CLINICS. By signing this form, I understand the informed consent and are giving permission to use and disclose my protected health information in accordance with the directives listed.

Patient's signature (Responsible Party if patient is under 18 years of age) (Date)

Aqua Therapy Clinics

FINANCIAL POLICY

Thank you for choosing Aqua Therapy Clinic as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

1. All patients must complete our information sheet.

2. Patients are responsible for contacting their insurance company and verifying their insurance benefits including policy deductibles, co-payment, coinsurance, visit limitations, and any pre-authorized requirements. As a courtesy, we will verify your coverage but will not guarantee the accuracy of the information we receive due to inconsistencies in insurance spokespersons and or timely filing and processing of your claims. Your insurance policy is a contract between you and your insurance company. We are not a part to that contract. Therefore, you are ultimately responsible for knowledge of insurance benefits and for the full payment of your bill.

3. Co-payments and/or co-insurance are due each visit.

4. If you do not have insurance, full payment is due at the time of service or a Wellness Package is obtained through our office.

5. We accept cash, credit and debit cards only.

Regarding Insurance

We bill insurance companies as a courtesy to our patients. However, you are ultimately responsible for co-payments, co-insurance or any part of the bill not paid by your insurance company. In trying to reduce their own costs, some insurance companies have lately developed a policy of unilaterally declaring "medical necessity has not been established" for portions of treatment. You are still responsible in this case for the services that were rendered.

In order for us to bill your insurance our patients must accept responsibility for providing the following documents:

1. A current doctor's prescription ordering therapy, stating diagnosis, frequency and duration (updated as necessary).

2. Copy of a valid insurance card. Please be aware that this office will require payment in full for treatment rendered if these documents are not provided. If your insurance company fails to reimburse us within 45 days, you will be responsible for the entire unpaid balance. If your insurance company is not paying on your claims we will ask you to check with your insurance company regarding the status of your claim prior to billing you directly, as a courtesy to you. ****** If your case is found to be the responsibility of a third-party insurance (other than your medical plan) then you will be responsible for the balance due in full. This form will serve as a medical lien in all court or settlement cases.***

Depending on your insurance plan, you might be required to pay a co-payment or co-insurance for services rendered. Since we will not be able to ascertain the exact dollar amount until after the insurance company processes claims, we will estimate that amount and collect that amount each visit. Once we have received payment from the insurance company, we will bill you for any amount not covered in the estimation or issue a refund check if you are in over payment.

Some insurance companies may send the check directly to you the patient, in your name. These checks are not for you as a reimbursement or any type of refund, they are for you to make payment to our Health Clinic for your visit. These Payments are expected within 15 days of the postal date or a 1.5% finance charge will be assessed on these delinquent accounts.

I understand that I am fully and completely responsible for the knowledge of my policy's benefits and limits, including number of visits, deductible amount, requirement of preauthorization (when indicated), and co-insurance or co-payment amounts. Again, as a courtesy we will try to obtain and manage this information for you, but there will be no guarantee that your insurance has provided the correct information at that time. We will not be able to ascertain the exact dollar amount until after the insurance company processes claims in some cases, so we will estimate that amount and collect that amount each visit.

*******A charge of $50.00 will be billed for any missed appointment without a 24 hour notice*******

Please let us know if we can help you with any of the above information! We want to help you to understand your insurance plan.

By my signature below, I recognize and accept that I am ultimately financially responsible for all charges for services rendered including, but not limited to, any services or fees denied or not covered by my insurance company.

I certify that I have read and fully understand all of the above information.

_____ _____

Signature of Patient (Responsible Party if patient is under the age of 18) Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our Practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We reserve the right to revise or amend the Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all or your records that our practice has created or maintained in the past, and for any or your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. We may use and disclose your PHI in the following ways:

1. **Treatment:** Our practice may use your PHI to treat you. For example, we may ask your physician for x-rays or operation reports and will send initial, progress and discharge reports to your physician.

2. **Billing:** Our practice may use and disclose your PHI in order to bill and collect payment for services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if you insurer will cover, or pay for, your treatment. At times, insurance companies will request chart notes.

3. **Quality Assurance Review:** Our practice is a member of Physical Therapy Provider Network and is requested to provide PTPN with one chart and billing records each year so that we can be tested for quality assurance.

4. **Attorney Cases:** Our practice may be requested to provide your attorney with information about your treatment if you have signed a “release of information” form.

5. **Appointment Reminders:** Our practice may use your PHI to contact you and remind you of an appointment.

6. **Release of Information to Guardian or Family Member:** Our practice may release your PHI to a guardian or family member that is involved in your care, or who assists in taking care of you. For example, a parent may request information about his/her child’s treatment.

7. **Disclosures Required by Law:** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law such as in cases of being subpoenaed.

8. **Worker’s Compensation:** Our practice may release your PHI for workers’ compensation programs.

9. **Other:** Other uses and disclosures will be made only with your written consent and may be revoked in writing.

C. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may request that we contact you at home rather than at work. In order to request a type of confidential communication, you must make a written request to Mark Ector COO (mector@aquatherapyclinics.com), or David Grywul CEO (dgrywul@aquatherapyclinics.com), specifying the requested method of contact…

You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of you PHI to only certain individuals involved in your care or the payment of your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, or emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Mark Ector COO (mector@aquatherapyclinics.com), or David Grywul CEO (dgrywul@aquatherapyclinics.com).

Your request must describe in a clear and concise fashion:
a. The information you wish to have restricted;
b. Whether you are requesting to limit our practice's use, disclosure or both;
c. To whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Mark Ector COO (mector@aquatherapyclinics.com), or David Grywul CEO (dgrywul@aquatherapyclinics.com), in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete. Your request must be in writing to Mark Ector COO (mector@aquatherapyclinics.com), or David Grywul CEO (dgrywul@aquatherapyclinics.com). Our practice may deny your request if you fail to submit your request in writing, individual or entity that created the information is not available to amend the information.

5. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices at any time. To obtain a copy of this notice, contact Mark Ector COO (mector@aquatherapyclinics.com), or David Grywul CEO (dgrywul@aquatherapyclinics.com).

6. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice in writing to Mark Ector COO (mector@aquatherapyclinics.com), or David Grywul CEO (dgrywul@aquatherapyclinics.com). You will not be penalized for filing a complaint.

7. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing.

Signature of Patient or Responsible Party if patient is under the age of 18) (Date)

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. **Worst Disability**

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. **Worst Disability**

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. **Worst Disability**

Occupation: This category refers to activities that are part of or directly related to one's job.

This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. **Worst Disability**

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. **Worst Disability**

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. **Worst Disability**

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. **Worst Disability**

Signature_____ **Please Print**_____

Date _____