

# AQUATIC HEALTH AND REHABILITATION SERVICES, INC.

## Patient Information: Please Fill out COMPLETELY:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male or Female: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Financial Information: (If patient is a minor please complete this information)

Name of Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information:** I hereby instruct the insurance company listed below to make payment to Aquatic Health and Rehabilitation Services, INC.

Primary Insurance Company: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

**Injury Due to accident:** Work: \_\_\_\_\_ Auto: \_\_\_\_\_ Other: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Adjustor / Case manager: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Do you have an Attorney? Y N \_\_\_\_\_

### **MEDICARE WAIVER**

I UNDERSTAND THAT MEDICARE WILL PAY ONLY 80% OF MY BILL AFTER I HAVE MET MY YEARLY DEDUCTIBLE. THE REMAINING 20% WILL BE MY RESPONSIBILITY UNLESS I HAVE FURNISHED AQUATIC HEALTH AND REHABILITATION SERVICES, INC A SECONDARY INSURANCE.

MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DEEMS TO BE "REASONABLE AND MEDICALLY NECESSARY" UNDER SECTION 1862 (A) (1) OF THE MEDICARE LAW. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH IT WOULD OTHERWISE BE COVERED, IS NOT "REASONABLE AND MEDICALLY NECESSARY" UNDER MEDICARE PROGRAM STANDARDS, MEDICARE WILL DENY PAYMENT FOR THAT SERVICE. WE WILL MAKE EVERY ATTEMPT TO DETERMINE, ACCORDING TO MEDICARE GUIDELINES, IF YOUR SERVICE IS "REASONABLE AND MEDICALLY NECESSARY" AND NOTIFY YOU IN THE EVENT MEDICARE DENIAL.

IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY RESPONSIBLE FOR PAYMENT OF SERVICES.

I understand that **all deductibles and co-pays must be paid at sign in on appointment day**. We accept cash, personal checks and major credit cards(VISA and Master Card) I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all of the information above and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

I hereby authorize any treatment(s), agreed upon with the Physical Therapist and my referring physician, which are deemed medically necessary.

I authorize release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. **MY DEDUCTIBLE IS: \_\_\_\_\_** **MY COPAY IS: \_\_\_\_\_**

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Aquatic Health & Rehabilitation Services, INC

595 N. Courtenay Pkwy  
Merritt Island, FL 32953  
Phone (321)453-8484

5360 N. Atlantic Ave # E  
Cocoa Beach, FL 32931  
Phone (321)799-8450

7185 Murrell Rd, Suite B  
Viera, FL 32940  
Phone (321)453-8484

### Consent Form

Client: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I have the authority to legally consent to treatment, medication, release of information and all issues involving the above named individual. Upon request, I will provide Aquatic Health and Rehabilitation Services, Inc. with the proper legal documentation to support this claim. I further agree that if my status as legal guardian should change, I will immediately inform Aquatic Health and Rehabilitation Services, Inc. and will provide the name(s), address and phone number(s) of the person(s) who have legally assumed guardianship of the above client.

#### Client Responsibilities:

1. Each clinic based therapy session consists of 30-60 minutes of treatment.
2. Privileged information given to the therapist and doctor is confidential and will only be released with proper authorization. The only exception to this privilege shall be legally mandated by Florida law.
3. An individualized treatment plan will be developed with the client, parent/legal guardian, and the therapist.
4. All deductibles and co-pays must be paid on appointment day. We accept cash, personal checks and major credit cards, (VISA and Master Card)
5. Efforts will be made to arrange appointments that will be as convenient as possible for you to attend. At times, compromises may be necessary. If you cannot keep a scheduled appointment please call to cancel or reschedule at least 24 hours in advance or you will be subject to a \$75.00 NO SHOW/LATE CANCEL fee.
6. If you repeatedly cancel your scheduled appointments or do not show up for three consecutive appointments without prior notification, your case will be reviewed and may be closed for failure to comply with the ordered treatment plan by your physician. If your case is closed, you, your physician and your insurance company will be notified in writing.
7. You will not be seen here if you are under the influence of any substance.
8. Weapons of any type are prohibited on any property where Aquatic Health & Rehabilitation Services, Inc is located.
9. There is a NO SMOKING policy in place within the buildings housing Aquatic Health & Rehabilitation Services, Inc.
10. I have read and understand Aquatic Health & Rehabilitation Services, Inc.'s policies and agree to abide by such. Please initial here \_\_\_\_\_.

#### Role of the Therapist:

The therapist will work with you to establish the goals for treatment specific to your individual diagnosis and problems. He/She will prepare a written plan of treatment which you, your physician and your therapist agree is possible to reach. Discharge planning will begin upon the first visit with the client always being informed of such.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**AQUATIC HEALTH AND REHABILITATION SERVICES, INC.**  
595 N. Courtenay Parkway #203  
Merritt Island FL, 32953  
Phone 321-453-8484 Fax 321-453-8448

5360 N. Atlantic Ave. #E  
Cocoa Beach FL, 32931  
Phone 321-799-8450 Fax 321-799-5452

### PATIENT MEDICAL RECORDS RELEASE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information [PHI]. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner [check all that apply]:

<input type="checkbox"/> Home Telephone _____	<input type="checkbox"/> Written Communication _____
<input type="checkbox"/> OK to leave message with detailed information _____	<input type="checkbox"/> OK to mail my home address _____
<input type="checkbox"/> Leave message with call-back number only _____	<input type="checkbox"/> E-Mail Communication; Email address _____
<input type="checkbox"/> Work Telephone _____	<input type="checkbox"/> OK to mail to my work address _____
<input type="checkbox"/> OK to leave message with detailed information _____	<input type="checkbox"/> OK to fax to this number _____
<input type="checkbox"/> Leave message with call-back number only _____	<input type="checkbox"/> Other _____

I would like to be reminded of my appointments by:

\_\_\_\_\_ Email to my email address: \_\_\_\_\_  
\_\_\_\_\_ Text message to my cell phone: \_\_\_\_\_

\_\_\_\_\_ I have received and read NOTICE OF PRIVACY PRACTICES.

I authorize AHRS to have access to my PHI or to provide my PHI to the following:

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Patient Signature

Date

Print Name

Birth Date

The Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

NOTE: Use and disclosure of PHI may be permitted without prior consent in an emergency.

# Aquatic Health and Rehabilitation Services, INC.

7185 Murrell Rd, Suite 101  
Viera, FL 32940  
Phone: 321-775-0406

595 N Courtenay Pkwy, #203  
Merritt Island, FL 32953  
Phone: 321-453-8484

5360 N Atlantic Ave  
Cocoa Beach, FL 32931  
Phone: 321-799-8450

## Cancellation and No-Show Policies

The following are our policies regarding **cancellations** and **no-shows**.

We take this subject very seriously at our clinics because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or therapist has prescribed a set frequency of treatment. Showing up and being on time as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments **that week** whenever possible.
- There is a **\$75 charge** for cancellation without proper notice. This charge is not be covered by insurance and will have to be paid by you personally.
- Worker's Compensation patients - documentation of any missed appointments will be forwarded to your Case Manager and Primary Physician. Not keeping your appointments could jeopardize your claim.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses. Either condition can seem to be a reason not to come in: a) you are feeling worse and think the treatment is not working or, b) you are feeling better and think you no longer need treatment.

**Neither of these conditions is legitimate as a reason not to come:**

- a) if you are in pain, come in and get it fixed,
- b) if you are out of pain, now is the time that we can begin doing some real correction of the underlying **causes** of your problem, and educate you so you won't re-injure yourself.

When you don't show as scheduled, three people are hurt: You, because you don't get the treatment you need as prescribed by your doctor; the therapist who now has a space in their schedule since the time was a reserved for you personally; and another patient who could have been scheduled for treatment if you had give proper notice.

Please co-operate with us in this regard. We are looking forward to working with you.

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Patient Signature

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Date

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Witness

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Date

1/2011

# AQUATIC HEALTH & REHABILITATION SERVICES, INC.

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

NAME: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

Are you currently seeing any of the following?

Medical doctor (M.D.)	YES	NO	Psychiatrist/Psychologist	YES	NO
Osteopath (D.O.)	YES	NO	Physical Therapist	YES	NO
Dentist	YES	NO	Chiropractor	YES	NO
Attorney	YES	NO			

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

**Existing or Relevant Previous Conditions**

		Start Date	End Date			Start Date	End Date			Start Date	End Date
Allergies	<input type="radio"/> Yes <input type="radio"/> No			Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No			MRSA	<input type="radio"/> Yes <input type="radio"/> No		
Anemia	<input type="radio"/> Yes <input type="radio"/> No			Emphysema/Bronchitis	<input type="radio"/> Yes <input type="radio"/> No			Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No		
Anxiety	<input type="radio"/> Yes <input type="radio"/> No			Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No			Muscular Disease	<input type="radio"/> Yes <input type="radio"/> No		
Arthritis	<input type="radio"/> Yes <input type="radio"/> No			Fractures	<input type="radio"/> Yes <input type="radio"/> No			Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No		
Asthma	<input type="radio"/> Yes <input type="radio"/> No			Galbladder Problems	<input type="radio"/> Yes <input type="radio"/> No			Parkinsons	<input type="radio"/> Yes <input type="radio"/> No		
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No			Headaches	<input type="radio"/> Yes <input type="radio"/> No			Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No		
Cancer	<input type="radio"/> Yes <input type="radio"/> No			Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No			Seizures	<input type="radio"/> Yes <input type="radio"/> No		
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No			Hepatitis	<input type="radio"/> Yes <input type="radio"/> No			Smoking	<input type="radio"/> Yes <input type="radio"/> No		
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No			High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No			Speech Problems	<input type="radio"/> Yes <input type="radio"/> No		
Chemical Dependency	<input type="radio"/> Yes <input type="radio"/> No			High/Low blood pressure	<input type="radio"/> Yes <input type="radio"/> No			Strokes	<input type="radio"/> Yes <input type="radio"/> No		
Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No			HIV/AIDS	<input type="radio"/> Yes <input type="radio"/> No			Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No		
Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No			Incontinence	<input type="radio"/> Yes <input type="radio"/> No			Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No		
Depression	<input type="radio"/> Yes <input type="radio"/> No			Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No			Vision Problems	<input type="radio"/> Yes <input type="radio"/> No		
Diabetes	<input type="radio"/> Yes <input type="radio"/> No			Metal implants	<input type="radio"/> Yes <input type="radio"/> No						

Please list any surgeries or other conditions for which you have been hospitalized for within the last few years, including the approximate date of surgery or hospitalization:

DATE      SURGERY/HOSPITALIZATION

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

DATE      INJURY      DATE      INJURY

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Have you recently noted?

Weight loss/gain	YES	NO	Nausea/vomiting	YES	NO
Fatigue	YES	NO	Weakness	YES	NO
Fever/chills/sweats	YES	NO	Numbness or tingling	YES	NO
Dizziness	YES	NO	Sleep pattern changes	YES	NO

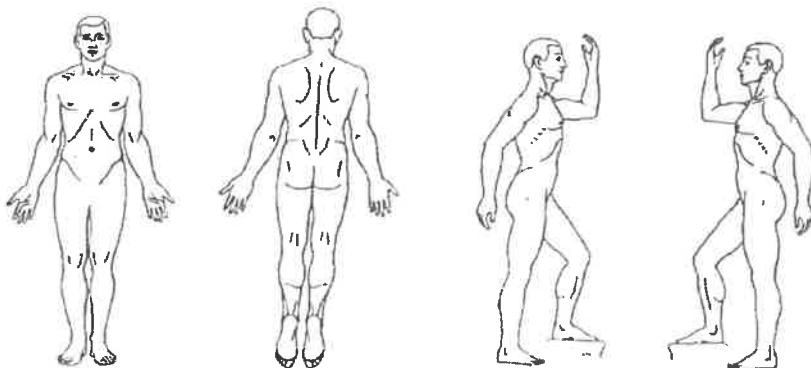
Please rate the severity of the symptoms/pain you are currently experiencing by circling the appropriate number. (0 being none and 10 being worst) 0 1 2 3 4 5 6 7 8 9 10

Please rate the severity of the symptoms/pain you are currently experiencing by circling the appropriate number. (0 being none and 10 being worst) 0 1 2 3 4 5 6 7 8 9 10

Please name three activities you have difficulty performing as a result of your current problem and rate on a 0-10 scale

<u>Activity</u>	<u>Unable to Perform</u>	<u>Perform at pre-injury level</u>
1 _____	0 1 2 3 4 5 6 7 8 9 10	
2 _____	0 1 2 3 4 5 6 7 8 9 10	
3 _____	0 1 2 3 4 5 6 7 8 9 10	

Please mark your symptoms below on the Body Chart.



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

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_  
Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Aspirin	YES	NO	Laxatives	YES	NO
Tylenol	YES	NO	Antacids	YES	NO
Advil/Motrin/Ibuprofen	YES	NO	Vitamins/Mineral Supplements	YES	NO
Decongestants	YES	NO	Other _____	YES	NO
Antihistamines	YES	NO			

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

How many packs of cigarettes do you smoke a day? \_\_\_\_\_

If one drink equals one beer or glass of wine, how much alcohol do you drink a week? \_\_\_\_\_

Form reviewed with patient YES NO

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Other Treating Physicians: \_\_\_\_\_

HOW DID YOU HEAR ABOUT Aquatic Health and Rehab?

\_\_\_\_\_