

Aquatic Health & Rehabilitation Services, INC.

595 N. Courtenay Pkwy
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) 799-8452

Welcome to Aquatic Health & Rehab !

_____ has an appointment on _____,

at ___ : _____ at the _____ office for a new patient

evaluation. **Please arrive 20 minutes prior to appointment time.**

Please bring completed attached paperwork, your insurance

cards, a list of medications, prescription if given to you by

physician and the enclosed paperwork to your appointment. If

you have a co-pay or deductible, you will be responsible for

payment at time of service.

Thank you for choosing Aquatic Health and Rehab

**IF YOU NEED TO CANCEL YOUR APPOINTMENT, PLEASE CALL 24
HOURS BEFORE YOUR APPOINTMENT TIME.**

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?

Cancer, if YES describe what kind:	YES	NO	Rheumatoid Arthritis	YES	NO
Heart Problems	YES	NO	Other Arthritic conditions	YES	NO
Circulation problems	YES	NO	Hepatitis	YES	NO
High Blood Pressure	YES	NO	Tuberculosis	YES	NO
Asthma	YES	NO	Stroke	YES	NO
Emphysema/Bronchitis	YES	NO	Kidney Disease	YES	NO
Chemical Dependence (Alcoholism)	YES	NO	Anemia	YES	NO
Thyroid problems	YES	NO	Epilepsy/Seizure disorders	YES	NO
Diabetes	YES	NO	Depression	YES	NO
Multiple Sclerosis	YES	NO	Osteoporosis	YES	NO
Pregnancy (Currently/past 1 yr)	YES	NO	Other	YES	NO
Prostate problems	YES	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:

<u>DATE</u>	<u>SURGERY/HOSPITALIZATION</u>
_____	_____
_____	_____

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:

<u>DATE</u>	<u>INJURY</u>	<u>DATE</u>	<u>INJURY</u>
_____	_____	_____	_____
_____	_____	_____	_____

Have you recently noted?

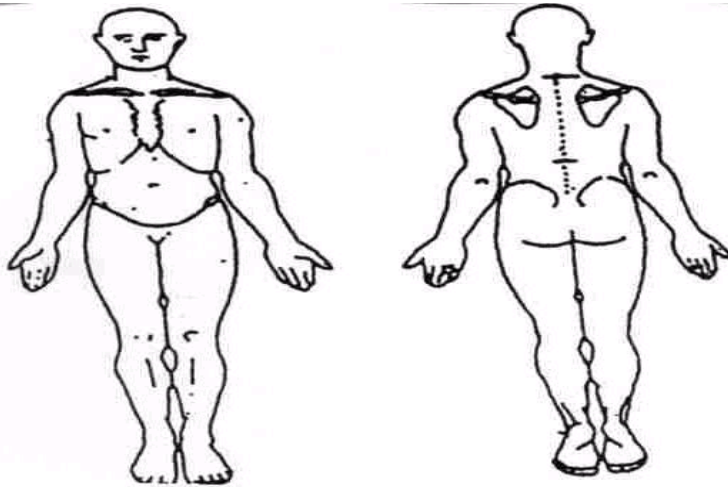
Weight loss/gain	YES	NO	Nausea/vomiting	YES	NO
Fatigue	YES	NO	Weakness	YES	NO
Fever/chills/sweats	YES	NO	Numbness or tingling	YES	NO
Dizziness	YES	NO	Sleep pattern changes	YES	NO

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 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):-

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 _____

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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.

Patient Information: Please Fill out **COMPLETELY:**

Last Name: _____ First Name _____ Middle Initial _____
Home Phone _____ Work Phone _____ Cell Phone _____
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** _____

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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]:

- Home Telephone _____
- OK to leave message with detailed information
- Leave message with call-back number only
- Work Telephone _____
- OK to leave message with detailed information
- Leave message with call-back number only
- Written Communication
- OK to mail my home address
- OK to mail to my work address
- OK to fax to this number _____
- Other _____

_____ 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:

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.