Aquatic Care Programs, Inc. Patient Information Date: _____

Name _____ **SS#** ____/____/____ **DOB:** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell** _____ **Email** _____

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Employer _____ **Work Phone** _____

Work Status ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed ☐ Student (Full-Time or Part-Time)

Referring Doctor _____ **Phone** _____

Primary Doctor _____ **Phone** _____

Have you had any of the following? ☐ Physical Therapy ☐ Chiropractic Treatment ☐ Occupational Therapy ☐ Speech Therapy

Please describe: _____

Is your injury related to a motor vehicle accident? ☐ Y ☐ N **Is your injury related to work?** ☐ Y ☐ N

Have you had surgery or are you scheduled for surgery? ☐ Y ☐ N **Date of surgery** _____

If this is a Worker's Comp Claim, then fill in below:

Employer where injured: _____ **Still employed here?** ☐ Y ☐ N **Phone** _____

Address _____

City _____ **State** _____ **Zip** _____

Date of injury _____ **Claim #** _____ **Old law claim?** ☐ Y ☐ N

Adjuster _____ **Phone** _____

Insurance company _____ **Phone** _____

Employer's Main Contact _____ **Phone** _____

Personal Insurance Information

Primary Insurance Co _____ **Phone** _____

Address _____

City _____ **State** _____ **Zip** _____

Primary Insured's Name _____ **SS#** _____ **DOB** _____

Insured ID# _____ **Group#** _____

Relationship to Patient ☐ Self ☐ Spouse ☒ Child ☐ Other **Sex** ☐ Male ☐ Female

Employer _____ **Phone** _____

Policy Holder Name _____ **Policy Holder DOB** _____

Secondary Insurance Information

Secondary Insurance Co _____ **Phone** _____

Address _____

City _____ **State** _____ **Zip** _____

Secondary Insured's Name _____ **SS#** _____ **DOB** _____

Insured ID# _____ **Group#** _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other **Sex** ☐ Male ☐ Female

Employer _____ **Phone** _____

Policy Holder Name _____ **Policy Holder DOB** _____

Emergency Contact Information

Who should we contact in case of emergency?

Name _____ **Phone** _____

All information is filled out to the best of my knowledge and is true.

Patient Signature _____ **Date** _____

Functional Ability

NAME:_____ **DATE:**_____

Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just check the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal Care (washing, dressing, etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently place (ex. on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently placed
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a cane or crutches
- ☐ I am in bed most of the time

Section 5- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me sitting more than 1 hour
- ☐ Pain prevents me sitting more than 30 minutes
- ☐ Pain prevents me sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing more than 1 hour
- ☐ Pain prevents me from standing more than 30 minutes
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7- Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent due to pain
- ☐ Pain prevents any sex life at all

Section 9 – Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (ex. sports)
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life due to pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Aquatic Care Programs, Inc. Medical History Summary

Name _____

Age _____ **Weight** _____

List all current medication and what they are used for.

Have you had any of the following:

Cold or influenza?	☐ Yes ☐ No
Respiratory Problems?	☐ Yes ☐ No
Ear, nose or throat problems?	☐ Yes ☐ No
Heart or blood pressure problems?	☐ Yes ☐ No
Endocrine (gland) problems?	☐ Yes ☐ No
Allergies?	☐ Yes ☐ No
Stomach problems?	☐ Yes ☐ No
Liver disease?	☐ Yes ☐ No
Nervous system disease?	☐ Yes ☐ No
Musculoskeletal/joint disease?	☐ Yes ☐ No
Skin or connective disease?	☐ Yes ☐ No
Metabolic problems?	☐ Yes ☐ No
OB/GYN problems?	☐ Yes ☐ No

Briefly explain any YES replies to the above questions:

Have you had any major illnesses, injuries or surgeries within the last 5 years? ☐ Yes ☐ No

If yes, please explain:

Do you have a chronic condition or pain we should be aware of? ☐ Yes ☐ No

If yes, please describe:

For the condition you are here for today, what makes your pain worse?

What makes your pain better?

Describe your symptoms:

List any other pertinent medical information or medical conditions we should be aware of:

List your goals for physical therapy:

Aquatic Care Programs, Inc.

8405 Wynbrook
Houston, TX 77061
BUS: (713) 454-6000 | FAX: (713) 454-6080

Physical Therapy Terms & Conditions

Cancellation/No-Show Policy

Due to the numerous cancellations and no-show appointments, our office has implemented a Cancellation/No-Show Policy. There will be one courtesy cancellation/no-show fee waived per month for each individual patient; any additional cancellations/no-shows will be charged a fee.

Appointments MUST be cancelled 24 hours before your scheduled appointments to avoid incurring a cancellation fee.

There will be a cancellation/no-show fee implemented for the following types of appointment:

1. Therapy appointment will be charged a cancellation fee of $25.00.
2. A Re-Evaluation/Progress note with or without treatment will be charged a cancellation fee of $35.00. (All patients who are scheduled for a re-evaluation/progress note will be notified the day before).

It is important that all patients make their scheduled appointment for compliance and to obtain the best possible results from their physical therapy sessions. If you must cancel, please call at least 24 hours before your appointment to avoid a cancellation fee and to allow other patients who need the therapy to schedule their appointment.

We ask that all patients please be considerate to call and cancel your appointment ahead of time so that other patients who are in need of treatment can be scheduled and avoid any cancellation/no-show fee.

Should it become necessary to cancel three consecutive appointments, the patient's status will be changed to "pending" until regular appointments can be resumed.

I have read and acknowledge the Cancellation/No-Show Policy implemented at Aquatic Care Programs, Inc.

Patient Name (Print) Date

Patient Signature

Aquatic Care Programs, Inc.

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Physical Therapy Terms & Conditions

Release of Liability

I fully understand that the physical therapy programs and water exercise programs offered by Aquatic Care Programs, Inc. require physical activity, and I hereby represent and acknowledge that my physical condition permits me to participate. I acknowledge that I have been advised that at any time I am having physical difficulty of any kind to notify the facility personnel and carefully stop all activity. I acknowledge and accept the responsibility and all of the risks.

Aquatic Care Programs, Inc. is not responsible for loss of or damage to any personal effects (money, jewelry, etc.) which I bring into the facility. I agree to abide by the facility rules and guidelines. I agree to conduct myself in a safe manner at all times.

I also release and discharge on behalf of myself, my heirs, assigns and successors in interest, all officers, directors, owners, agents and employees, and other representatives of Aquatic Care Programs, Inc. and its insurers, from any and all claims, damages, demands, losses, and liabilities arising out of or in any way related to participation in any in Aquatic Care Programs, Inc.'s physical therapy programs, exercise programs, class activities, procedures, swim or any other activities or results attained there from. The patient is informed that Aquatic Care Programs, Inc.'s facility is under continuous 24 hour per day audio and visual surveillance.

_____

Patient Name (Print)

_____

Patient Signature

_____

Date

Aquatic Care Programs, Inc.

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Houston, TX 77061
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Physical Therapy Terms & Conditions

Patient Responsibility and Insurance Considerations

Deductibles and co-insurance payments are due at the time services are rendered. We accept cash, checks, Visa, MasterCard, Discover and American Express. We will accept assignment of insurance benefits, as shown in the enclosed Assignment of Benefits form, and will file your insurance claims as a courtesy; however, all charges are your responsibility. We will gladly discuss your treatment plan and review questions relating to your insurance. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.

Our fees are generally considered usual and customary for the geozip; however, this statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

- I hereby authorized Aquatic Care Programs, Inc. to bill my primary insurance company for services I receive. Furthermore, I authorize Aquatic Care Programs, Inc. to bill any applicable secondary and tertiary insurance coverage I may have.
- In the event I am covered under Personal Injury Protection (PIP) auto insurance (auto accident), I hereby authorize Aquatic Care Programs, Inc. to bill my PIP company. I also authorize Aquatic Care to bill the other party's insurance company and l also authorize Aquatic Care to bill my private insurance company and (if married) my spouse's private insurance company.
- I hereby instruct and direct my insurance company to pay directly: Aquatic Care Programs, Inc. And if my policy prohibits direct payment to this facility, l instruct my insurance company to make the check to me and mail it to Aquatic Care Programs, Inc., 8405 Wynbrook Street,
  Houston. TX 77061.
- I authorize e-file release of any medical information pertinent to my case to any treating medical specialist(s), insurance company, Medicare or attorney in this case, as applicable.
- l authorize this facility to initiate a complaint to the Insurance Commissioner on my behalf, if needed.
- l agree to immediately notify Aquatic Care Programs, Inc. immediately of any changes in my insurance status.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for my charges, and negotiated amount, and/or denied charges by my insurance.
- I have read all the information in this agreement and I certified this information is true and correct to the best of my knowledge, and I agree to terms and conditions herein.

Patient Name (Print) Date

Patient Signature

Aquatic Care Programs, Inc.

8405 Wynbrook
Houston, TX 77061
BUS: (713) 454-6000 | FAX: (713) 454-6080

Physical Therapy Terms & Conditions

Informed Consent

In connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor, or facility, or provider solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility.

I certify that I was informed of the effective alternative resources reasonably available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity. I certify that my attending physician(s) has made referrals to other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality of care and safety that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

Patient Name (Print) Date

Patient Signature

Aquatic Care Programs, Inc.

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Physical Therapy Terms & Conditions

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND / OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Aquatic Care Programs, Inc. as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose in action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the abovenamed health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense, or in its own name.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Patient Name (Print) Date

Patient Signature