AQUACARE | FITNESS FORUM
PHYSICAL THERAPY

Office Intake Forms

Prior PHYSICAL THERAPY CARE: Have you had or currently receiving any Physical Therapy elsewhere in the last 12 months?
Choose one.

- ☐ **Yes. If so, where and how many visits were you seen for? _____**
- ☐ **No**

Prior CHIROPRACTIC CARE: Have you had or currently receiving any Chiropractic care in the last 12 months?
Choose one.

- ☐ **Yes. If so , where and how many visits were you seen for? _____**
- ☐ **No.**

Prior HOME HEALTH CARE: Have you had or currently receiving any Home Health Care in the last 12 months?
Choose one.

- ☐ **Yes. If so , the date you were discharged. _____**
- ☐ **No.**

HIPAA-Contact Information:

Please list person(s) authorized to discuss medical information:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have read and been offered a copy of the Notice of Privacy Practices from Aquacare Physical Therapy and Fitness Forum. I am aware that a copy will be provided to me at any time by Aquacare Physical Therapy and Fitness Forum, per my request.

☐ **I agree to terms listed and all information provided is accurate.**

Patient Name (printed) : _____ Date of Birth: _____

Signature: _____ Date: _____

☐ **Patient** ☐ **Legal Guardian** ☐ **Power of Attorney**

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Aquacare Physical Therapy Financial Policy

Welcome to our practice. As a courtesy to you, Aquacare Physical Therapy will file claims to your insurance carrier(s) for the services that are provided. To ensure that your claims process correctly and timely, please make sure that the information provided to our office is accurate and current. If there is a change in your insurance information, please notify us immediately.

IF YOU HAVE A COPAY FOR YOUR PHYSICAL THERAPY BENEFITS, IT WILL BE COLLECTED AT EACH VISIT.

IF YOU HAVE A COINSURANCE AND/OR DEDUCTIBLE FOR YOUR PHYSICAL THERAPY BENEFITS, YOUR FINANCIAL RESPONSIBILITY WILL NOT BE KNOWN UNTIL YOUR INSURANCE(S) PROCESS YOUR CLAIMS. EACH INSURANCE COMPANY PROCESSES CLAIMS USING DIFFERENT FEE SCHEDULES. YOU WILL BE BILLED FOR ANY AMOUNTS THAT YOUR INSURANCE COMPANY(S) DESIGNATES AS PATIENT RESPONSIBILITY.

YOU ARE ULTIMATELY RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT AND

OUTSTANDING OR UNCOVERED SERVICES.

PAYMENT METHODS AND OTHER INFORMATION:

- **We accept cash, check and credit cards. Payment plan options are available.**
- **Home supplies are NOT covered by insurance. We are not a DME supplier.**
- **Accounts past due will be turned over to a collections attorney.***
- **We will bill your auto insurance as a courtesy to you. In the event your Personal Injury Protection (P.I.P.) becomes exhausted, we will then bill your health insurance, if applicable. You will be responsible for any deductibles, coinsurance and/or copays required by your health insurance.**

If your insurance plan(s) renews during your treatment of care your benefits will be re-verified as a courtesy. Your financial obligation may change as a result.

***In the event my account becomes delinquent and requires collection referral, I understand, acknowledge and agree that I will be responsible for all costs incurred including but not limited to reasonable attorney's fees of thirty-three and one-third percent (33.3%) of the balance owed, collection agency fees, court and process service costs. Jurisdiction and Venue: If any suit must be filed to collect an unpaid balance on an account, patient, and/or guarantor, agrees that such suit may be brought in the courts of Wicomico County, Maryland, and waives any objection to jurisdiction or venue. I give my permission to be contacted by phone either at home or work.**

☐ **I agree to terms listed and accept responsibility for payment of all charges incurred.**

Patient's Name: _____ Date of Birth: _____

Legal name of the person who is completing the forms (printed). _____

Signature: _____ Date: _____

☐ **Patient** ☐ **Legal Guardian** ☐ **Power of Attorney**

AQUACARE | FITNESS FORUM PHYSICAL THERAPY

The Missed Visit Policy

At Aquacare/Fitness Forum Physical Therapy, our goal is to help all patients fully recover from injury and illness. At the end of your initial appointment, your physical therapist will provide you with a plan for your care based on their expertise and your goals.

Patients who attend all their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lowered potential for recovery. We do what we do to make sure YOU, and all our patients, have the best chance at recovery; but we need your participation in the plan of care to make that happen. To prevent others from having to wait for their care, we also need your compliance with our attendance policy.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To make sure you have the best chance at recovery, you'll need to schedule and arrive for your prescribed visits.
2. **We will begin your treatment sessions on time**, so we need you to arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at your scheduled appointment time.
3. **If you're running late**, we need you to call as soon as you know you're running late. We will check with your provider to make sure there's enough time to provide the care you need and deserve.
   - If you are more than 15 minutes late, your session may need to be rescheduled and our missed visit policy will apply at that time. Chronically late patients will be asked to change their appointment times.
4. **If you are sick at any time during care, we need you to call us as soon as you have symptoms**. Please don't wait for the day of your appointment. At that time we will provide a plan for what happens next.
   - Example: If you're sick on Monday but your appt is Wednesday, let us know Monday.
5. **If you need to cancel or change a scheduled appointment, for any reason, we need notice by 3pm the business day before.**
   - This allows enough time to get you rescheduled AND help another patient get in for the care they need and deserve.
   - When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
6. **If you don't provide notice by 3 pm the business day before for an appointment change or cancellation, you will be charged a $25 fee.**
   - This fee will be charged on your 3rd and any subsequent canceled/missed appointments if appropriate notice is not given.
   - This fee is your responsibility and is due at the time of your next service due to the inconvenience and disruption it creates for other patients seeking care.
   - We will comply with payer policy in carrying out this policy.
   - For worker's comp patients, we're required to notify your claims adjuster for cancellations and no-shows.
   - No-show appointments create problems and confusion and are not accepted. Call for any change or update.
7. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule, and placed on our day-to-day list to avoid future last-minute cancellations that keep other patients from care or will be discharged from care.

As I'm sure you understand, one patient's late (or lack of) notice for appointment changes or cancellations keeps other patients from getting the care they need and deserve. You can avoid any problems with this policy by calling our office during business hours by 3pm the business day before for any illness, appointment changes or cancellations.

Cara Konlian (CEO), Steven Konlilan (CFO), Jennifer O'Neill (COO)

This policy has been verbally reviewed with me and by signing below I am indicating that I understand this policy.

Patient Signature	Patient Name	Date

AQUACARE | FITNESS FORUM
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POOL SAFETY

(Pool Therapy may NOT be part of your treatment plan)

The staff and management of Aquacare Physical Therapy are very proud that we are able to offer extensive aquatic therapy services to our patients. We also recognize that providing treatment in the pool requires additional responsibility and measures on behalf of our staff as well as our clients. While we are dedicated to taking every measure to ensure the pool and the men's and women's locker rooms are kept in good condition, please understand that it is also your obligation to practice safe behavior and habits, including following these recommendations:

1 . Patients identified as having an increased risk of falls will be asked to use the chair lift to get into and out of the pool, especially at the end of your session.
2. Please make sure you bring your towel with you out to the pool, and that you towel off immediately after getting out of the pool and before you walk to the locker-room.
3. Use well-fitting, non-skid footwear within the locker rooms as well as on the pool deck. Please note that flip-flops and thong sandals can be tripping hazards and are strongly discouraged.
4. While changing, take advantage of areas in the locker rooms that are outfitted with mats, benches, and chairs. Sit down while dressing versus standing, especially if standing will require you to balance on one leg.
5. Bring an extra towel with you to place on the floor to stand on while dressing.
6. Use the handicapped stall equipped with rails when using the bathroom, especially if you have a history of falls and/or balance deficits.
7. Use the handicapped shower equipped with rails and bench, particularly if you have a history of falls and/or balance deficits.
8. Adhere to the caution signs posted in the locker rooms.
9. Be aware of your surroundings. Please inform staff if you notice any pooling water or other issue you feel we should address.

Thank you so much for choosing Aquacare for your rehabilitation needs! We look forward to working with you and returning you to the best version of yourself!

☐ **I have read and understand the safety precautions provided to me by Aquacare Physical Therapy regarding use of the pool and locker rooms.**

Patient Name (printed) : _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

☐ **Patient** ☐ **Legal Guardian** ☐ **Power of Attorney**

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Telehealth

I understand that telehealth is an option for treatment if I am unable to come in physically for treatment.

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site then the provider; and hereby consent to Aquacare Physical Therapy providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that there is the possibility of failure of the technologies used to provide telehealth services. All efforts will be made to find a means for telehealth that is available for me as the patient.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Aquacare Physical Therapy. As long as this consent is in force (has not been revoked) Aquacare Physical Therapy may provide health care services to me via telemedicine without the need for me to sign another consent form.

☐ **I agree to the terms listed.**

Patient Name (printed) : _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

☐ **Patient** ☐ **Legal Guardian** ☐ **Power of Attorney**

Consent to Treat

By signing below, I consent to physical therapy treatment to be provided by Aquacare Physical Therapy personnel. I understand I will be provided with a description of my individualized physical therapy treatment plan. It will include the potential benefits and any associated risks of physical therapy. I understand that my attendance, in accordance with the prescribed treatment plan, is critical to maximizing the potential benefits of my physical therapy treatment plan. I authorize the release of all medical information necessary to process medical claims. I also authorize the insurance company to make payment directly to Aquacare Physical Therapy for services rendered and understand that I am fully responsible for all charges incurred for treatment.

Patient Name (printed) : _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

☐ **Patient** ☐ **Legal Guardian** ☐ **Power of Attorney**