Alaska Aquatic & REHAB THERAPY

35392 Kenai Spur Hwy. Soldotna, AK 99669 | Ph: 907-398-0411 | Fax: 866-502-3411

Patient Information

Last Name: _____ **First Name**_____ **Gender Identity**_____
Nickname: _____ **Date of Birth:**____/____/_____ **Age:** _____ **SSN:** _____/____/_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
E-mail Address:_____
Cell Phone: (_____)_____-_____ **Home Phone:** (_____)_____-_____
Is it okay to leave a message about your appointment or care? Yes ☐ No
Emergency Contact: _____ **Phone:** (_____)_____-_____
Referring Provider:_____ **Primary Care Provider:**_____

Person responsible for the bill ❑ *same as above*

Last Name: _____ **First Name**_____
Date of Birth:____/____/_____ **SSN:** _____/____/_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Cell Phone: (_____)_____-_____ **Home Phone:** (_____)_____-_____
E-mail Address:_____

Insurance information ❑ *same as card*

Primary Insurance:_____
Policy #: _____ **Group #:**_____
Mailing Address: _____
City:_____**State:**_____ **Zip:**_____
Insurance Phone: (_____)_____-_____
Name of Policy Holder: _____
Policy Holder DOB: ___/_____/_____

Secondary Insurance:_____
Policy #: _____ **Group #:**_____
Mailing Address: _____
City:_____**State:**_____ **Zip:**_____
Insurance Phone: (_____)_____-_____
Name of Policy Holder: _____
Policy Holder DOB: ___/_____/_____

Medication Information:

❑ *see attached list* *OR* ***list*** *all medications, prescription and non-prescription*

Medication: _____ **Dosage/Frequency:** _____**Prescribing Provider:**_____
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Do you have a pain contract? ❑No ❑Yes If Yes, name of overseeing provider? _____

I have received or reviewed a copy of the Privacy Policy.

Name: _____Signature: _____ Date:_____

What pain, surgery or other problem brings you to therapy today? _____

_____

About when did your symptoms start, and/ OR date of surgery?_____

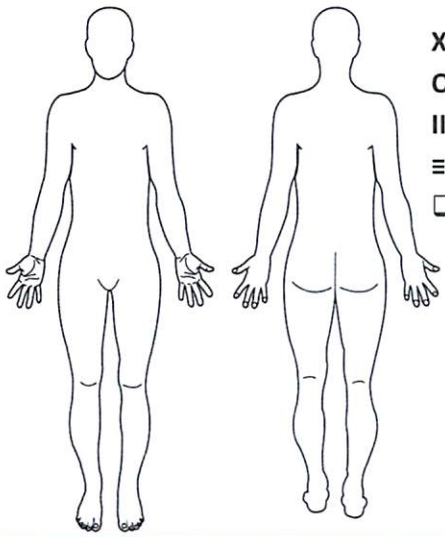
What do you think caused your symptoms? _____

_____

Have you had these symptoms before? ❑Yes ❑No If so, how did it improve?_____

Body Chart

Please mark the areas where you feel symptoms:



X Shooting / sharp pain
O Dull / Aching pain
III Numbness / Tingling
≡ Burning
❑Other

Previous Treatments & Tests

Please list all procedures (surgeries, injections, special labs)

Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____

Imaging Studies Completed within the last 2 years:
❑ Xray ❑ MRI ❑ CT

Previous Treatment received:
❑ PT ❑ OT ❑Chiropractic ❑Massage ❑ Acupuncture

Symptoms

Currently, My Symptoms:
❑ Come & go ❑ Are Constant ❑ Change with activity
❑ Getting Better ❑ Getting Worse ❑ Staying the same

Please Circle Current Pain Level

no pain 0—1—2—3—4—5—6—7—8—9—10

Rate your *current* functional level:
❑No Difficulty ❑Mild Difficulty ❑Moderate Difficulty ❑Severe

*Please Circle **BEST*** Pain Level

no pain 0—1—2—3—4—5—6—7—8—9—10

When are your symptoms the best?
❑ Morning ❑ Afternoon ❑ Night ❑ After moving around

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

*Please Circle **WORST*** Pain Level

no pain 0—1—2—3—4—5—6—7—8—9—10

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Does your pain radiate? ❑Yes ❑No

Does it wake you up at night? ❑No ❑Yes; # Times/night____

What are you limited in doing because of your symptoms? ❑Walking ❑Standing ❑Sitting ❑Driving ❑Bending ❑Lifting ❑Twisting ❑Working ❑Cooking ❑Eating ❑Bathing ❑Sleeping ❑Dressing ❑Grooming ❑Other _____

What do you enjoy doing in your free time?_____

What are you unable to do now that you would like to be able to do again? _____

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Systemic Symptoms

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ changes in bowel or bladder function
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ headache
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ falls (within the last year)

Medical Diagnoses: Current and/or past

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ Cancer: Type_____
- ❑ Heart Problems: Type_____
- ❑ Heart attack: Date_____
- ❑ High blood pressure
- ❑ Circulation problems
- ❑Neurological Disorder (❑MS ❑ALS ❑other)
- ❑ Diabetes (❑Type I ❑Type II)
- ❑ Thyroid problem (❑Hyper ❑ Hypo)
- ❑ Arthritis (❑OA ❑RA)
- ❑Broken Bone_____Date:_____
- ❑ Pneumonia / lung problems
- ❑ Blood clots
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Epilepsy / seizures
- ❑ Eye problem/infection
- ❑ Bladder/urinary tract infection
- ❑ Kidney problem/infection
- ❑ Gastric reflux (GERD) or ulcers
- ❑Psychiatric Disorder: (anxiety ❑ depression ❑ bipolar❑ other❑)
- ❑ Anemia or blood disorder
- ❑ Stroke: Date_____
- ❑ Osteoporosis/ osteopenia
- ❑ Migraines
- ❑ Fibromyalgia
- ❑ High cholesterol
- ❑ Hepatitis
- ❑ Liver problems
- ❑ HIV

Your Health

Do you use tobacco? ❑No ❑Yes If Yes, what type? _____ How much per day? _____

Do you have any implanted device or medical piece in your body? ❑No ❑Yes If Yes, specify: _____

Please list any allergies: _____

Height:_____ Weight:_____

Your Home and Work Life

With whom do you live? _____

Do you have caregiver assistance? ❑No ❑Yes; Hours per week? _____

Do you use any equipment to help you at home? ❑Bath chair ❑Grab bars ❑Cane ❑Walker ❑Wheelchair ❑other____

Do you have stairs in your home? ❑No ❑Yes If yes, how many ? _____ Is there a handrail? ❑No ❑Yes

Employment Status: ❑Employed ❑Homemaker ❑Unemployed ❑Retired ❑Disabled ❑Social Security Benefit Receiver

Occupation:_____ Employer:_____ Return to work date: _____

Specific Job Requirements: ❑prolonged sitting ❑prolonged standing ❑lifting ❑other_____

YOUR GOALS

What do you hope to learn from coming to therapy? _____

_____

_____

_____

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PATIENT FINANCIAL POLICY

Thank you for choosing Alaska Aquatic Therapy. We understand that many patients find financial matters surrounding their medical care to be very complex and often confusing. If you have any questions, please ask to speak with our billing department.

Private Health Insurance	Initial Here _____	As the patient, you are responsible for requesting prior approval and/or out of network benefit level exceptions from your insurance company as required. Our office collects payments due at the time of service. You will be billed for any amount not covered by your plan in addition to your deductible, and/or co-insurance amounts not collected at the time of service.
Medicaid	Initial Here _____	We are a contracted provider with Medicaid. You must present a current card for each month of eligibility. Please note, a referral is required if you are in the Medicaid program, Without a referral you will be considered a self-pay patient.
Medicare	Initial Here _____	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. You will be billed for any remaining deductible, co-insurance amounts and/or patient notified non-covered services after Medicare processes your claim.
Tricare Triwest VA	Initial Here _____	We are a network provider with Tricare and Triwest. We will bill Tricare and Triewest on your behalf as a courtesy. You will be responsible for any amount balance not covered by your plan. VA visits must be preauthorized by your referring physician.
Workers Compensation	Initial Here _____	We only accept Workers' Compensation claims that were filed with the Alaska Department of Labor.
Self-Pay Uninsured	Initial Here _____	Payment is due in full at the time of service unless other billing arrangements have been made by Alaska Aquatic Therapy.
Auto Accident	Initial Here _____	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance) . Once your medical benefits are exhausted your private insurance may be billed. You must contact your private insurance to disclose your liability claim. If you have no other insurance, your account will be transferred to a self-pay status.

- ✓ I have read, understand and agree to this financial policy
- ✓ I understand that I am ultimately responsible for my balance, not my insurance carrier
- ✓ I authorize Alaska Aquatic Therapy to release medical information to my insurance carrier to facilitate payment
- ✓ I understand that my signature authorizes benefits to be paid directly to Alaska Aquatic Therapy
- ✓ I understand that should my account balance become delinquent, the balance may be referred to a collection agency.
- ✓ I will be held responsible for all fees associated with collection of my account balance.

Name of Patient:_____ Signature:_____

Date: _____

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Patient Name:	SSN:
AKA Name(s):	Date of Birth:

Person/Organization to receive information: _____

Person/ Organization to release information: _____

Description of information to be released: _____

I authorize the use and disclosure of health care and/or other information as described above:

- I understand that the Notice of Use of Private Health Care Information describes my rights and how my information will be used
- My authorization is voluntary, but a refusal to sign this authorization may affect my enrollment or eligibility, for benefits
- Because my records may contain sensitive information, the individuals and organizations named are limited to requesting and releasing the minimum amount of information necessary.
- My information to be released to others who must continue to keep this information confidential to the extend required by federal and state law.
- I may specify the length of time for my authorization to be in effect
- My authorization may be revoked at any time in writing on a form that states it is a revocation of my authorization, but the revocation will have no effect on actions that happened before it was received.
- I may request a copy of this signed authorization

This authorization expires on the following date or event: _____

_____ _____
Signature of named individual or legal representative Date

_____ _____
Printed name of legal representative or witness Description of representative's authority

PATIENT RELEASE OF INFORMATION AUTHORIZATION REQUIRED FOR ALL PATIENTS
HIPPA COMPLAINT

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NO SHOW AND CANCELLATION POLICY

Alaska Aquatic Therapy is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. To serve you and others better:

PLEASE CALL OUR OFFICE BY 4:00PM ON THE DAY PRIOR TO YOUR SCHEDULED APPOINTMENT TO NOTIFY US OF ANY CHANGES OR CANCELLATIONS.

Failure to do so will result in a LATE CANCELLATION. The policy is as follows:

1st Late Cancel = Warning / Reminder of policy

2nd Late Cancel = $25.00 Fee

3rd Late Cancel = $25.00 Fee and Future Appointments cancelled

◯ I understand that if I fail to make my appointments or fail to cancel the day prior to 4:00pm, I risk a fee or cancellation of my future appointments.

◯ I have read, understand, and agree to uphold this written policy concerning cancellations and no shows.

_____ _____

Printed Name Signature Date