Alaska Aquatic Therapy

Physical • Occupational • Speech

Dear Future Patient:

Welcome to Alaska Aquatic Therapy! (AAT). We are so glad to be part of your journey/return to improved physical & emotional well being. AAT has been serving the therapeutic needs of the people for over 18 years. Our goal here at AAT is to lead our patients to become independent with an exercise program that is water based, and may have land opportunities. This typically should take a period of 6 to 12 weeks depending on the patient's abilities, injuries, etc. We focus on independence NOT dependence on others, so our patients have the confidence to continue their healing process after discharge from AAT.

If your needs require the help of a caregiver, we will train them to assist you in your program. You may expect to be scheduled 1-2x a week for aqua therapy. You will be instructed in an individualized program that will help you achieve the goals that you and your therapist have set. We also offer a "free" group Ai Chi exercise session. When you have completed your program, you will have a laminated copy of your program that you may take with you when you go to the pool independently from AAT.

The next few weeks you will be expected to be at therapy at your scheduled time. It is very important that you arrive and are ready to begin at the time of your scheduled appointment. Please do not come late or too early. If you come late, you may have limited time with your therapist. If you have to cancel therapy, please do so in a timely manner (within 24 hrs). We also have a strict NO SHOW policy that will be enforced, please refer to your enrollment packet.

At the end of each month we will be reviewing your goals and request additional time or discharge depending on your progress and physician approval.

Thank you and we look forward to working with you!

AAT STAFF

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PATIENT INFORMATION

Patient Name (full): _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Birth Date: _____ Age: _____

Driver's License/Government ID number: _____

Social Security #: _____ Occupation: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Primary Care Physician: _____

FINANCIALLY RESPONSIBLE PERSON

Insured: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Birth Date: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Other person to notify in emergency: _____ Phone: _____

Driver's license/Government ID number: _____

MEDICAL INSURANCE COVERAGE

Primary Insurance Company and Billing Address: _____

_____

ID/Policy #: _____ Group #/Name: _____ Subscriber: _____

Secondary Insurance Company and Billing Address: _____

_____

ID/Policy #: _____ Group #/Name: _____ Subscriber: _____

Workman's Comp Insurance Company and Billing Address: _____

_____

Employer: _____ Claim #: _____ Date of Injury: _____

Claims Adjuster: _____ Phone: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION: *(Please read and sign)*
I hereby authorize payment of medical benefits to ALASKA AQUATIC THERAPY, INC. for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient Signature: _____ Date: _____

Name: _____ Date: _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: Height: Weight:
Are you on a work restriction from your doctor? Yes No Are you latex sensitive? Yes No
Do you smoke? Yes No Do you have a pacemaker? Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

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
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

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

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

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

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? YES NO
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

I should not do physical activities that might make my pain worse: ❑ Disagree ❑ Unsure ❑ Agree

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

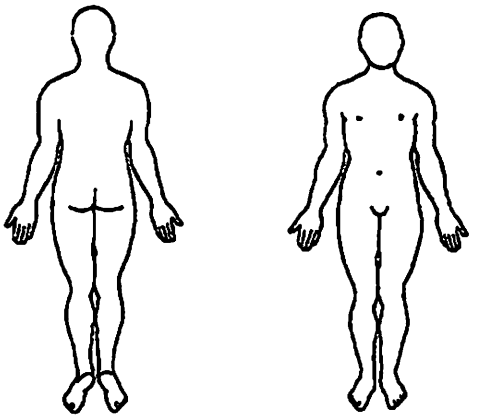
Have you ever had this problem before: ❑ Yes ❑ No When_____ Treatment rec'd_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

X Shooting/sharp pain
o Dull/aching pain
||| Numbness
= Tingling



My symptoms currently: ❑ **Come and go** ❑ **Are Constant** ❑ **Are constant, but change with activity**

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

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ **No problem sleeping** ❑ **Difficulty falling asleep** ❑ **Awakened by pain** ❑ **Sleep only with medication**

When are your symptoms worst? ❑ **Morning** ❑ **Afternoon** ❑ **Evening** ❑ **Night** ❑ **After exercise**
When are your symptoms the best? ❑ **Morning** ❑ **Afternoon** ❑ **Evening** ❑ **Night** ❑ **After exercise**

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

RELEASE OF PATIENT INFORMATION
AUTHORIZATION FORM

PATIENT NAME:	SSN:
AKA NAME(S):	DATE OF BIRTH:

PEOPLE & ENTITIES I AUTHORIZE TO RECEIVE MY PROTECTED HEALTH INFORMATION	
NAME OF ENTITY	**CONTACT INFORMATION**

Please list medical practitioner(s), spouse, caregiver(s), guardian(s), etc. you are authorizing to receive PHI.

The purpose of this release of protected health information authorization:
I hereby authorize the use or disclosure of my health care and/or other information within my patient record to the entities stated above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section at the bottom of this form, or by notifying Alaska Aquatic Therapy, Inc. in writing, but if I do, it will not affect actions taken on this authorization before my revocation was received. I understand that Alaska Aquatic Therapy, Inc. will not condition my treatment, payment, or eligibility for services based on whether I provide this authorization.

I understand that if the person(s) or entities I authorize to receive my protected health information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipients of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event:
Signature of Patient or Personal Representative: Date (Or Witness if signature is by mark)
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:
NOTE: This authorization was revoked on: _____ (see attached revocation). Complete when/if revoked. Date

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL *Revised 11/09/09*

PATIENT RELEASE OF INFORMATION AUTHORIZATION
REQUIRED FOR ALL PATIENTS
HIPAA COMPLIANT

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Acknowledgement of Patient Privacy Notification:

The purpose of the form is to acknowledge your consent for treatment, authorization for billing and the conditions under which your medical information may be used.

1. **The undersigned consents to the examination and procedures as outlined by his/her physician including any emergency treatment services and/or therapy procedures rendered.**
2. **The undersigned authorizes, whether he/she signs as agent or patient, direct payment to Alaska Aquatic Therapy of any insurance benefit billed on behalf of the patient or otherwise payable of services rendered.**
3. **I UNDERSTAND AND AGREE THAT I AM ULTIMATELY REPSONSIBLE FOR ALL CHARGES ASSOCIATED WITH MY MEDICAL TREATMENT.**
4. **I understand that insurance claims billed on my behalf are strictly a courtesy provided by AAT (except for Medicare, Medicaid, and Worker's Compensation).**
5. **I agree that a photocopy of this form may be used in lieu of an original, and I allow a Fax transmittal of medical information, if needed, and agree to have my medical records released as needed.**
6. **Alaska Aquatic Therapy, Inc. does utilize the services of a collection agency, and I agree to pay all reasonable attorney's fees and collection cost in the event of default of payment.**
7. **I understand the circumstances under which my medical record information may be released without my expressed consent.**
8. **I understand that the Patient Privacy Notice gives full disclosure of how AAT may use my medical information. You have the right to a paper copy of the Patient Privacy Notice and may ask us to give you a paper copy of this Notice at any time.**

I have read, fully understand the above, and have received a copy of this document.

Signature of Patient, Guardian, or Legal Representative:

_____ **Date:** _____

Witness: _____

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This form is used to aknowledge understanding and agreement with the terms of Alaska Aquatic Therapy, Inc. Financial Policy.

By signing below, I understand and agree to the following terms:

- **Full payment is expected at the time of service.**
- **We accept Visa, MasterCard, Debit Card, checks, and cash.**
- **We accept and will bill the following programs: Medicare, Medicaid, Denali Kid Care, and Alaska Workers Compensation. Patients with VA or Alaska Native Health coverage must obtain authorization prior to being seen.**
- **We will courtesy bill primary and secondary insurance. We do not bill automobile insurance unless prior arrangements have been made with our billing office.**
- **We will assist those with documented financial needs to make payment arrangements, if possible.**
- **Account statements that show patient and insurance company responsibility and activity are sent monthly.**
- **Accounts that are 90 days or more past-due and have not had any activity may be sent to a collection agency.**
- **We will charge a $25.00 NSF Fee for all checks returned by your banking facility.**

Date: _____

Patient Name (Printed): _____

Signature of Patient, Guardian, or Legal Representative:

_____

Cancellation Policy

Patient's Name: _____

Alaska Aquatic Therapy is committed to the highest standard of practice. Our staff is dedicated to providing you quality of service. We appreciate you allowing us to serve you. We want to communicate clearly our policies to you in advance in order to avoid any confusion or misunderstandings that might develop.

- Please call a **minimum of 24 hours in advance** if you need to cancel an appointment. This allows us to schedule a patient on the wait list in your spot. It is unfair to the wait list patients and the therapists to not allow for other patients to be scheduled in the open time slots.

- If a session is 15 minutes or more delayed due to a late arrival, you will be charged a **$15.00 late fee** due prior to the scheduled appointment. Unfortunately Medicaid, DKC and private insurance companies do not reimburse for late fees.
  _____ Initials

- If the patient misses a scheduled appointment without prior notification this will be counted as a no-show. The patient will be charged a **$50.00 no-show fee** due prior to the next scheduled appointment. Unfortunately Medicaid, DKC and private insurance companies do not reimburse for no-show fees.
  _____ Initials

- If you have two **consecutive no-shows** you will be placed on hold. If the issue is not resolved within one week you will be taken off the schedule and placed on the waiting list.
  _____ Initials

- We require a **75% attendance rate**. As a courtesy we will keep track of this for you each month. If your attendance drops below 75% you will be placed on the wait list. Note: an exception to this would be an extended period such as a trip or other extenuating circumstances where you will be absent. This will require that you discuss your plan ahead of time with your therapist. If the extended cancellation is over 3 weeks your spot on the schedule will not be held and will be fit back into the schedule as soon as possible upon your return.
  _____ Initials

I hereby understand to the above cancellation policy and agree to abide by it.

Patient/Legal Guardian Signature _____ **Date** _____

Effective 11/09/09