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?

Allergies	YES	NO	Gallbladder Problems	YES	NO
Anemia	YES	NO	Hepatitis	YES	NO
Anxiety	YES	NO	High Blood Pressure	YES	NO
Arthritis	YES	NO	Incontinence	YES	NO
Asthma	YES	NO	Kidney Problems	YES	NO
Cancer	YES	NO	Metal Implants	YES	NO
Cardiac Conditions	YES	NO	Multiple Sclerosis	YES	NO
Cardiac Pacemaker	YES	NO	Osteoporosis	YES	NO
Chemical Dependency	YES	NO	Rheumatoid Arthritis	YES	NO
Circulation Problems	YES	NO	Seizures	YES	NO
Currently Pregnant	YES	NO	Speech Problems	YES	NO
Depression	YES	NO	Strokes	YES	NO
Diabetes	YES	NO	Thyroid Disease	YES	NO
Dizzy Spells	YES	NO	Tuberculosis	YES	NO
Emphysema/Bronchitis	YES	NO	Vision Problems	YES	NO
Fractures	YES	NO			

FALLS HISTORY

Injury as a result of a fall in the past year? YES NO Date of Fall_____
Two or more falls in the last year? YES NO Dates of Falls_____

Surgical History

Body Region: _____ Surgery Type: _____ Date of Surgery:_____
Body Region: _____ Surgery Type: _____ Date of Surgery:_____
Body Region: _____ Surgery Type: _____ Date of Surgery:_____
Body Region: _____ Surgery Type: _____ Date of Surgery:_____
Body Region: _____ Surgery Type: _____ Date of Surgery:_____

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:

DATE	INJURY	DATE	INJURY

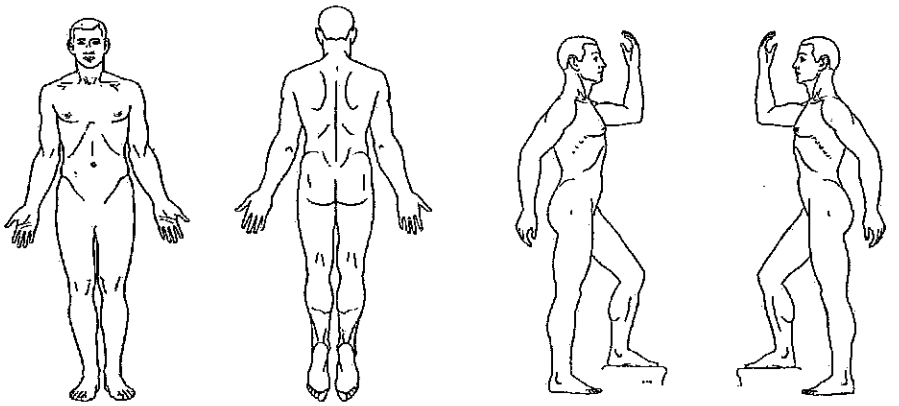
Have you recently noted?

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 name three activities you have difficulty performing as a result of your current problem and rate on a 0-10 scale

Activity	Unable to Perform	Perform at pre-injury level
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):

Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____
Drug: _____ Dosage: _____ Reason for Taking:_____

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_____

Primary Physician:_____

OtherTreatingPhysicians:_____
_____

HOW DID YOU HEAR ABOUT Aquatic Health and Rehab?
_____
_____

AQUATIC HEALTH AND REHABILITATION SERVICES, INC.

Patient Information: Please Fill out COMPLETELY:

Last Name: _____ First Name _____ Middle Initial _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email_____

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 _____

Aquatic Health and Rehabilitation Services, INC.

7185 Murrell Rd, Suite 101
Viera, FL 32940
Phone: 321-775-0406

595 N Courtenay Pkwy, #203
Merritt Island, FL 32953
Phone: 321-453-8484

5360 N Atlantic Ave
Cocoa Beach, FL 32931
Phone: 321-799-8450

Cancellation and No-Show Policies

The following are our policies regarding **cancellations** and **no-shows.**

We take this subject very seriously at our clinics because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or therapist has prescribed a set frequency of treatment. Showing up and being on time as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments **that week** whenever possible.

- There is a **$75 charge** for cancellation without proper notice. This charge is not be covered by insurance and will have to be paid by you personally.

- Worker's Compensation patients - documentation of any missed appointments will be forwarded to your Case Manager and Primary Physician. Not keeping your appointments could jeopardize your claim.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses. Either condition can seem to be a reason not to come in: a) you are feeling worse and think the treatment is not working or,
  b) you are feeling better and think you no longer need treatment.

Neither of these conditions is legitimate as a reason not to come:
a) if you are in pain, come in and get it fixed,
b) if you are out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, and educate you so you won't re-injure yourself.

When you don't show as scheduled, three people are hurt: You, because you don't get the treatment you need as prescribed by your doctor; the therapist who now has a space in their schedule since the time was a reserved for you personally; and another patient who could have been scheduled for treatment if you had give proper notice.

Please co-operate with us in this regard. We are looking forward to working with you.

_____ _____
Patient Signature Date

_____ _____
Witness Date

AQUATIC HEALTH AND REHABILITATION SERVICES, INC.
595 N. Courtenay Parkway #203
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 321-799-5452

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

□ E-Mail Communication; Email address _____
- □ OK to mail to my work address
- □ OK to fax to this number _____
- □ Other _____

I would like to be reminded of my appointments by:

_____ Email to my email address: _____
_____ Text message to my cell phone: _____

_____ 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.

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Merritt Island, FL 32953
Phone (321)453-8484

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Cocoa Beach, FL 32931
Phone (321)799-8450

7185 Murrell Rd, Suite B
Viera, FL 32940
Phone (321)453-8484

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:** _____