COMPLIANCY POLICY

Thank you for choosing Aquahab Physical Therapy for your physical therapy program. We strive to help our patients and will make every effort to schedule appointments that are the most convenient for you. Our fully staffed clinics have day, evening, and weekend hours available to serve you.

In order to maintain our high quality of care and to provide adequate staffing for all patients, all therapy is by appointment only. We urge you to schedule your appointments in advance and to make every effort to attend. **If you are unable to attend, you must contact the clinic by 4 P.M. the day before your scheduled appointment to avoid a cancellation fee.** In all fairness to other patients, this will enable us to provide them with the opportunity to attend in your absence.

In addition, if you arrive 15 minutes late or more for your scheduled appointment – or come to therapy without a scheduled visit – you may be asked to reschedule your appointment. In fairness to your fellow patients, arriving late or showing up without a scheduled appointment can adversely affect their care.

Cancellation Fees: Cancellation calls received after 4 P.M. the day before your scheduled appointment and no shows will be assessed a cancellation fee of **$25 for routine visits and $50 for initial evaluations with the exception of emergencies.**

Irregular attendance and non-compliancy with your program will very likely produce a poor outcome with your treatment results. These factors may also affect your insurance company's decision to pay for your treatment, leaving you responsible for any services not covered because of your failure to follow through with the program established for you. Your employee attendance record and/or any pending litigation cases may also be adversely affected by non-compliance. Patients who show a repeat pattern of unexcused absence and/or non-compliancy will be discharged**. Patients who miss a visit agree to make up that appointment in the same week**. In the event that a patient misses 3 visits that patient's chart will be discharged and the referring provider will be notified.

I understand the compliancy policy of Aquahab Physical Therapy and agree to abide by the terms of this agreement. My signature below constitutes my acceptance of these terms.

Patient's Signature Date

Signature of Aquahab's Representative Date

Aquahab Physical Therapy Consent To Use/Disclose Health Information Form

Although Aquahab Physical Therapy is not required by law to obtain a signed consent from you for treatment, payment, or healthcare operations purposes, we encourage you to sign this consent form so that you are aware of our concern and practices regarding protectio your personal healthcare information.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have a review a Notice of Privacy Practices (the "Notice) prior to signing this consent.

The Notice is available by contacting the Privacy Officer. Please note that Aquahab Physical Therapy reserves the right to change the privacy practices described in the Notice. If you wish to obtain a revised Notice, please contact the Privacy Officer.

By signing this consent, you agree that Aquahab Physical Therapy may use or disclose your protected health information to carryout treatment, payment, or healthcare operations.

You have the right to request that Aquahab Physical Therapy restrict how your protected health information is used or disclosed to carryout treatment, payment, or healthcare operations. However, Aquahab Physical Therapy is not required to agree to such restrictions. If Aquahab Physical Therapy does agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this request in writing, except to the extent that Aquahab Physical Therapy has taken action in reliance on your consent.

Acknowledgement and Agreement:

I consent to Aquahab Physical Therapy sending protected health information to the insured in the event that I am receiving treatment but not the insured under my insurance policy. Such information may include, but not limited to, explanation of benefits (EOB) or invoices regarding my treatment. I understand if I do not want such protected health information mailed to the insured, then I will notify Aquahab Physical Therapy of my objection and will complete a Request for Restriction of Use and Disclosure Form.

In Addition, I understand and accept the risk of unintentional disclosure of my protected health information because the treatment area is an open area where I and other patients are treated simultaneously. I understand that some of my protected health information maybe inadvertently overheard by other patients, therapists or supportive staff. I also agree not to disclose any protected health information I might inadvertently overhear about other patients while I am receiving treatment in the open treatment area.

I consent to Aquahab Physical Therapy releasing my protected health information to the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

I have received a copy of Aquahab Physical Therapy's Notice of Privacy Practices. I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

_____ _____

Print Patient's Name Aquahab Physical Therapy

_____ _____

Signature of Patient or Representative Date

FINANCIAL POLICY

Patient's Name: _____ Date: _____

As a courtesy, we will bill your insurance carrier for services rendered by Aquahab Physical Therapy. Please read the following information so that you may understand our policy regarding your financial obligation with us.

___***Private Health Ins.:*** We will bill your Insurance carrier directly. There may be a co-ins payment or Co-pay for this type of coverage. Your co-pay is $_____ per visit. Your plan has a deductible of $ _____ and coinsurance of _____%. You have agreed to pay $_____ towards your coinsurance and/or deductible each visit.

____***Personal Choice/AmeriHealth Pc:*** We will bill your Insurance carrier directly. There may be a co-ins payment or Co-pay for this type of coverage. Your co-pay is $_____ per visit. Your plan has a deductible of $ _____ and coinsurance of _____%. You have agreed to pay $_____ towards your coinsurance and/or deductible each visit.

____***Motor Vehicle:*** We will bill your insurance carrier for you. In the state of **Pennsylvania,** it is your responsibility to know the amount of your medical benefits and if you are close to exhaustion. It will be your responsibility to provide us with your health insurance information at the time of service. However, if they do not pay, you will be responsible for the balance. In the state of **New Jersey**, there is a deductible of $250.00 and a 20% co-insurance. If you have health insurance, we can balance bill the company for your deductible and coinsurance. This information needs to be provided at the time of service.

___***Worker's Compensation:*** We will bill your insurance carrier for you. Your bill will be considered paid in full when payment is received form your worker's comp Carrier. If it is determined not to be work related you will be responsible for the balance. It is necessary that you supply your health insurance information as back up coverage in case of denial or rejection as a work-related injury.

___***Medicare:*** We participate with Medicare in both Pa and NJ. You will be subject to the annual Medicare deductible and allowed 20% portion of the approved bill. If you have secondary coverage we will bill the 20% to the secondary carrier separately as long as the information was given to us at the beginning of treatment.

I have read and understand this financial policy. I agree to pay **Aquahab Physical Therapy** any balance due after my insurance carrier has fulfilled their obligation on my behalf.

Responsible Party: _____

Date: _____

AQUAHAB PHYSICAL THERAPY

Patient Registration Form

Date Of Eval:_____ **Date of Intake:**_____ **Patient ID:**_____

Name:_____ **Date of Birth:**_____ **SS#**_____

Address:_____
Street City State Zip Code

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Contact Preference: Home___Work___Cell___ **Email Address:**_____

Sex: Male___Female___ Marital Status: Single__Married__ Spouse's Name:_____ **DOB:**_____

Employer:_____ **Employer's Address:**_____

Date of Accident/Injury:_____ **POST-OP Date:**_____

Type of Accident: MVA WC OTHER Injury Area:_____

HOW DID YOU HEAR ABOUT US: FRIEND HOSPITAL TV DOCTOR ONLINE NEWSPAPER ATTORNEY OTHER

DOCTOR INFORMATION

Referring Physician: (who referred you to Physical Therapy)	Office Phone:
Primary Care Physician:	Office Phone:
Emergency Contact:	Phone:

INSURANCE INFORMATION- (PLEASE PRESENT YOUR INSURANCE CARDS)

Primary Insurance:_____ **ID#**_____ **Group#:**_____

Phone:_____ **Subscriber's Name:**_____ **DOB:**_____

Patient's relationship to subscriber: SELF___SPOUSE___CHILD___PARENT___OTHER_____

Secondary Insurance:_____ **ID#**_____ **Phone:**_____

Subscriber's Name:_____ **DOB:**_____

IF YOU HAD AN ACCIDENT/WORK INJURY PLEASE COMPLETE THIS SECTION

Insurance Company:_____ **Claim Number:**_____

Address:_____ **Phone Number:**_____

Claims Adjuster Name:_____ **Phone Number:**_____

Attorney Name:_____ **Phone Number:**_____

Firm Name:_____ **Address:**_____

HISTORY PHYSICAL THERAPY AND/OR HOME HEALTH CARE

Have you received Out-patient Physical Therapy or Speech Therapy in this calendar year? _____
If yes,
When:_____Where:_____What:_____

Have you received any outpatient Occupational Therapy in this Calendar year?_____
If yes,
When:_____Where:_____What:_____

Have you received Home Health Care/ or been in a Skilled Nursing Facility in the last 3 months?____
If yes, what Agency? _____
When were you discharged? _____

AQUAHAB PHYSICAL THERAPY

MEDICAL/SOCIAL HISTORY

With whom do you live?

- □ Alone □ Spouse only
- □ Spouse and child(ren)
- □ Child(ren) only □ Other relatives
- □ Other _____

Where do you live?

- □ Private home □ Apartment
- □ Assisted living/ group home
- □ Other _____

Does your home have:

- □ Stairs, no railing □ Stairs, railing
- □ Ramps □ Elevator
- □ Assistive devices _____
- □ Obstacles _____

Do you use:

- □ Cane □ Glasses
- □ Walker □ Hearing aids
- □ Wheelchair □ Incontinence Products

Please check if you have ever had:

- □ Arthritis
- □ Broken bones, fractures
- □ Osteoporosis
- □ Blood disorders
- □ Circulation/vascular disorder
- □ Heart problems
- □ Pacemaker
- □ High blood pressure
- □ Lung problems
- □ Stroke
- □ Diabetes/high blood sugar
- □ Low blood sugar/hypoglycemia
- □ Head injury
- □ Multiple sclerosis
- □ Muscular dystrophy
- □ Parkinson's disease
- □ Seizures/ epilepsy
- □ Developemental/growth disorders
- □ Thyroid problems
- □ Cancer
- □ Infectious disease
- □ Kidney problems
- □ Ulcers/ stomach problems

Is there any chance that you are currently pregnant?

□ Yes □ No

Within the past year, have you had any of the following symptoms:

- □ Chest pain
- □ Heart palpitations
- □ Shortness of Breath
- □ Dizziness or blackouts
- □ Coordination problems
- □ Weakness in arms or legs
- □ Loss of balance
- □ Difficulty walking
- □ Joint pain or swelling
- □ Pain at night
- □ Difficulty sleeping
- □ Loss of appetite

- □ Nausea/ vomiting
- □ Weight loss/ gain
- □ Incontinence
- □ Bladder, bowel or bathroom issues
- □ Other _____

- □ Skin diseases
- □ Depression
- □ Other_____

Have you ever had surgery?

□ Yes □ No

Surgery_____ Date_____

Do you take prescription medications?

□ Yes □ No

If yes, please list _____

Do you take any non-prescription medication? □ Yes □ No

- □ Advil/Aleve
- □ Ibuprofen/ Naproxen
- □ Aspirin
- □ Tylenol
- □ Other _____

Within the past year, have you had any of the following tests?

- □ Arthroscopy
- □ Biopsy

- ☐ Blood tests
- ☐ Bone scan
- ☐ CT scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EMG
- ☐ EKG
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve conduction velocity
- ☐ Pulmonary function test
- ☐ Stress test
- ☐ X-rays
- ☐ Other: _____

I certify that all of the information on this intake form is true and correct to the best of my knowledge and that I understand the policies of Aquahab Physical Therapy (Center). I give my consent to receive any and all treatment that is rendered at Aquahab Physical Therapy. I am responsible for notifying the Center of any changes in my health or billing information. I give consent for the Center to bill my insurance company and for assignment of direct payment to the Center by my insurance company. The Center will make every effort to collect payment from my insurance company, however I understand that regardless of my account status, I am ultimately responsible for all charges incurred for professional services rendered at Aquahab Physical Therapy to the extent that the law allows.

Signature_____**Date**_____

I authorize the release of any all information in your possession, custody, and control, including x-rays, medical records, and emergency room records and test reports. The undersigned expressly authorizes the release of my complete hospital/physician's office chart to Aquahab Physical Therapy. I also give consent for the Center to release their records, within the guidelines of the law, as necessary to my physician, insurance company, rehab nurse/case manager or attorney.

Signature_____**Date**_____