916 N. Dixie Freeway
New Smyrna Beach, Florida 32168
Phone: 386-426-7885 Fax: 1-866-239-9013
bluewatertherapy1@gmail.com

Patient Registration Form

Patient Information

Date:_____ Home Phone:_____ Cell phone:_____
Name: _____ Soc Sec. No._____-_____-_____
Address:_____ DL#_____
City:_____ State:_____ Zip:_____
Sex: □Male □Female Age:_____ Date of birth:_____
Email address:_____ Can we email you at this address:_____
□Single □Married □Widowed □Separated □Divorced

Emergency Contact Information

In case of an emergency who should we contact?
Name:_____ Home Phone:_____ Cell Phone:_____
Relationship to you?_____

Primary Insurance

Insurance Company:_____
Contract#_____ Group#:_____ Subscriber#_____
Person Responsible for Account:_____
Address(If different from patient):_____
City:_____ State:_____ Zip:_____
Relationship to Patient:_____
Person Responsible Employed by:_____ Occupation:_____
Business Address:_____ Business Phone:_____

Additional Insurance

Is the patient covered under additional insurance? □YES □NO
Insurance Company:_____ Subscriber#_____
Contract#_____ Group#:_____
Person Responsible for Account:_____
Address(If different from patient):_____
City:_____ State:_____ Zip:_____
Relationship to Patient:_____
Name of other Dependents Covered Under this Policy:_____
_____

_____ _____ _____
Responsible Party Signature Relationship Date

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Medical History

Patient Name:_____ D.O.B_____
Name of Physician:_____ Phone #_____

Are you in good health? □ Yes □ No

In the last five years have you been: (if yes, please explain)

a. Hospitalized? □ No □Yes _____
b. Had a serious illness? □No □Yes_____
c. Had a major operation? □No □Yes_____

Please check the following that pertain to you:

□ No known significant PMH to affect treatment
□ Alzheimer's
□ Cardiovascular Disease/ Murmur
□ Cauda Equina Syndrome
□ Cerebral Vascular Accident / Stroke
□ Current Infection
□ Diabetes Mellitus Type 1
□ Diabetes Mellitus Type 2
□ Fibromyalgia
□ Fractures or Suspected Fractures
□ Seizures/Epilepsy
□ Psychiatric/ Mental Disorders /PTSD
□ High or Low Blood Pressure
□ Pacemaker
□ Joint Replacement _____
□ Seizures/Epilepsy
□ Blood Transfusion
□ Hepatitis, Jaundice or Liver Disease
□ History of Cancer_____
□ Huntington's
□ Immunosuppression
□ Lupus
□ Muscular Dystrophy
□ Obesity
□ Osteoarthritis
□ Parkinson's
□ Rheumatoid Arthritis
□ Traumatic Brain Injury
□ Asthma
□ Aids/HIV
□ Sinus Trouble/ Sinusitis
□ Drug Addiction /Alcoholism
□ Kidney Disease
□ Lung Disease/Tuberculosis
□ Hemophilia or Excessive Bleeding

□ Other:_____

□ MRI or X-rays / Where were they taken: _____

Please list all allergies or unusual reactions that pertain to you:

_____

_____

Patient
Signature_____ Date:_____

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Medication List

Medication	Dosage	Route	Frequency	Start Date

_____I am on no medications at this time. **(Please check if on no medications)**

Other:_____

_____

_____

Patient Name:_____ Date:_____

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Consent to Treatment

Consent to treatment:

I hereby grant consent for treatment or services to be provided by Blue Water Therapy therapists, training staff/team.

Disclosure of Protection Health Information:

I understand that my health information is protected by federal regulations under either the Health Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without my authorization or consent. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation.

I understand that my protected health information will or could be used by Blue Water Therapy staff for purposes of providing athletic training and medical services, reporting and providing information, and communication with administers, physical therapist, doctors, and other allied health professionals. Medical information shared between medical providers and all parties involved in my medical treatment along with Blue Water Therapy is confidential information and will not be shared to those outside of these positions.

I hereby consent to and authorize Blue Water Therapy health care personnel to disclose protected health information and any related information regarding any injury or illness during my treatment and participation to the individuals or entities noted above for the purposes stated above. I also consent to authorize the release of protected health information to the following listed below:(i.e. spouse, healthcare surrogate)

_____

_____

I also understand that the local, regional and national media are not covered by HIPAA or FERPA and these legal requirements will not apply.

_____ _____

Patient Signature Date Guardian Signature Date

_____ _____

Print Name Print Guardian Name

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Medical Records Release and Request Form

I (the undersigned) give my consent for Blue Water Therapy to request and receive any and all medical documents related to my treatment of physical therapy performed through them. I also hereby authorize Blue Water Therapy to release medical information necessary to any and all parties involved in my medical treatment (example: health care providers, insurance carriers, attorney or any other person representing me on my behalf).

_____

Patient Signature or Guardian Date

_____

Print Name or Guardian Date

_____

Date of Birth

_____

Treating Physician

CANCELLATION POLICY

If you are unable to follow the prescribed treatment plan and have 2 or more cancellations or no shows to your appointments without a 24 hour notice, we reserve the right to discharge you until which time your schedule permits your consistent participation in your rehabilitation program. There will also be a fee of $25.00 each time that you will be charged. We strive to achieve the highest standard of care.

_____ **I have read and understand the cancellation policy**

Initial

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Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, auto or any other health/medical plan, to issue payment check(s) directly to BLUE WATER THERAPY INC., for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize BLUE WATER THERAPY INC., to (1) release any information necessary to insurance carriers regarding my treatments and condition; (2) process insurance claims generated in the course of examination of treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from BLUE WATER THERAPY INC. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges not covered by insurance if any incurred in the course of the treatment.

I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____

Patient/Responsible Party Signature Date

_____

Witness Date

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Financial Responsibility Form

□ Automobile Liability :

I understand that medical care is being rendered to me as a result of an automobile accident. Blue Water Therapy agrees to submit all charges to my insurance carrier as a service to me. However Blue Water Therapy will expect payment in full from me if my insurance has not responded. I understand it is not the policy of this office to accept "Letters of Protection" from an attorney unless prior arrangements have been made.

□ Medicare :

As a Medicare recipient, I understand that Blue Water Therapy does participate with Medicare. This means that Blue Water Therapy will file my claim with Medicare, but I am responsible for my 20% of the allowed amount (co-insurance). I understand that in accepting Medicare, Blue Water Therapy is also required to collect any unpaid deductibles and co-insurance amounts. If I have a secondary insurance coverage, Blue Water Therapy will file my claim with my secondary insurance carrier. After 30 days, if they have not responded, I agree to pay all co-insurance and deductible amounts that are outstanding in full to Blue Water Therapy.

□ Workers Compensation :

As a patient receiving Worker's Compensation benefits as a result of a work related injury, I understand that the services rendered to me by Blue Water Therapy are covered as per the State of Florida Worker's Compensation fee Schedule. I understand, I have no financial responsibility to Blue Water Therapy for services rendered to me UNLESS my Worker's Compensation benefits are retroactively denied by the employer or Worker's Compensation. If this occurs, I understand that I will be responsible for all partial or unpaid claims.

□ Commercial Insurance :

I understand that services being provided to me by Blue Water Therapy are covered in whole or part by commercial insurance coverage. However, I also understand that I am ultimately responsible for any uncovered charges. Blue Water Therapy will file all insurance claims and hold my account 45 days pending insurance payment. If my insurance does not pay within 45 days or only pays part of the claim. I understand that I am responsible for any outstanding charges. I agree to pay my co-pay on each date of service.

□ Self Pay :

I understand that it is the policy of Blue Water Therapy to collect all payments at the time of services are rendered. I also understand that since I do not have insurance coverage for these services, I agree to pay Blue Water Therapy's bill with check, cash or credit card.

Print Name:_____ **Date:**_____

Signature:_____ **Date:**_____

Witness:_____ **Date:**_____

Name:_____

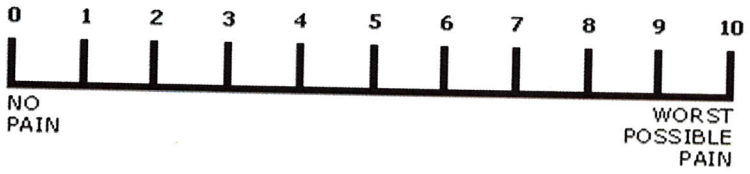
Date pain / discomfort began:_____

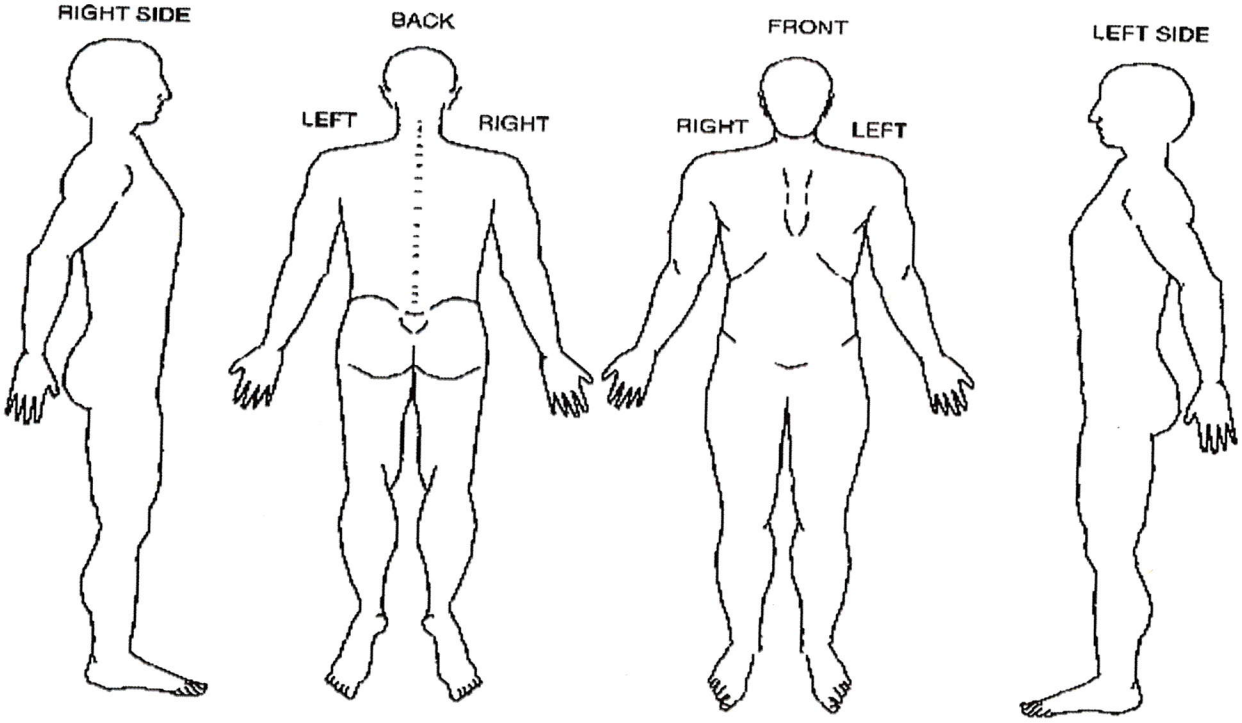
Date of surgery (if surgery was performed):_____

Height:_____ Weight:_____

Please mark an **"X"** over the areas of your discomfort/pain, then circle the number on the scale for how you would rate your discomfort/pain (0 to 10).

0-10 Numeric Pain Intensity Scale





Have you fallen 2 or more times in the past 2 years **WITH injury**? Yes or No

Have you had 1 fall or **NO falls** in the past year with **NO injury**? Yes or No

I have not fallen in the past 2 years. _____ (please initial)