Patient Registration Form

916 N. Dixie Freeway
New Smyrna Beach, FL 32168
Office: (386) 426-7885
Fax: 1-866-239-9013
Email: bluewatertherapy1@gmail.com

Patient Information

Date: _____ Home Phone: _____ Cell Phone: _____

Name: _____

Address: _____ DL#: _____

City: _____ State: _____ Zip: _____

Gender: ☐ Female ☐ Male Age: _____ Day of Birth: _____

Email Address: _____

Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Emergency Contact Information - *In case of an emergency, who should we contact?*

Name: _____ Relationship to you: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance

Insurance Company: _____ Subscriber #: _____

Contract #: _____ Group #: _____

Person Responsible for Account: _____ Relationship: _____

Address: (if different from patient): _____

City: _____ State: _____ Zip: _____

Employer of Responsible Party: _____ 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: _____ Relationship: _____

Address: (if different from patient): _____

City: _____ State: _____ Zip: _____

Employer of Responsible Party: _____ Occupation: _____

Name of other dependents covered under this policy: _____

_____

_____ _____ _____

Responsible Party Signature | Relationship | Date

Medical History

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Patient Information

Name: _____ Date of Birth: _____

Name of Physician: _____ Phone #: _____

Are you in good health? ☐ Yes ☐ No

In the last 5 years have you been: (if yes, please explain)

Hospitalized? ☐ No ☐ Yes _____

Had a serious illness? ☐ No ☐ Yes _____

Had a major operation? ☐ No ☐ Yes _____

Illnesses or Conditions (please check all 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: _____
- ☐ 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 Addition/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 pertains to you:

_____

_____

_____

_____ _____

Patient Signature Date

Medication List

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Medication	Dosage	Route	Frequency	Start Date

☒ I am not on any medications at this time. (please check if on no medications)

Other:

Print Patient Name

Date

Consent to Treatment

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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 Insurance Portability and Accountability Act (HIPAA) 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 purposes stated above. I also consent to authorizing 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

Medical Records Release & Request Form & Cancellation Policy

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Medical Records Release & 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 _____

Printed Name or Guardian _____ Patient 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 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 $35 each time per office visit and $45 per pool visit that you will be charged. We strive to achieve the highest standard of care.

By signing below, I acknowledge that I have read and understand the cancellation policy.

Patient Signature _____ Date _____ Guardian Signature _____ Date _____

Print Name _____ Print Guardian Name _____

Assignment of Benefits

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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. The 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 insurance 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 dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not coveted 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 of its 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 Printed Name

Patient/Responsible Party Signature _____ Date

Witness _____ Date

Financial Responsibility

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☐ 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 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 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 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 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.

Patient/Responsible Party Printed Name

Patient/Responsible Party Signature _____ Date

Witness _____ Date

Pain Intensity Scale

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Name: _____

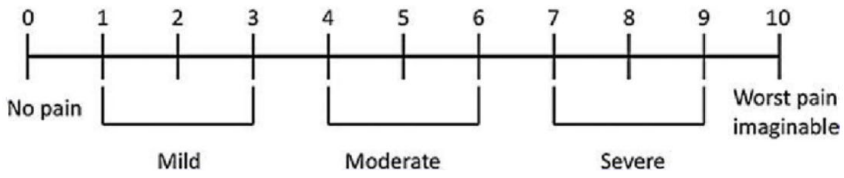
Date pain/discomfort began: _____

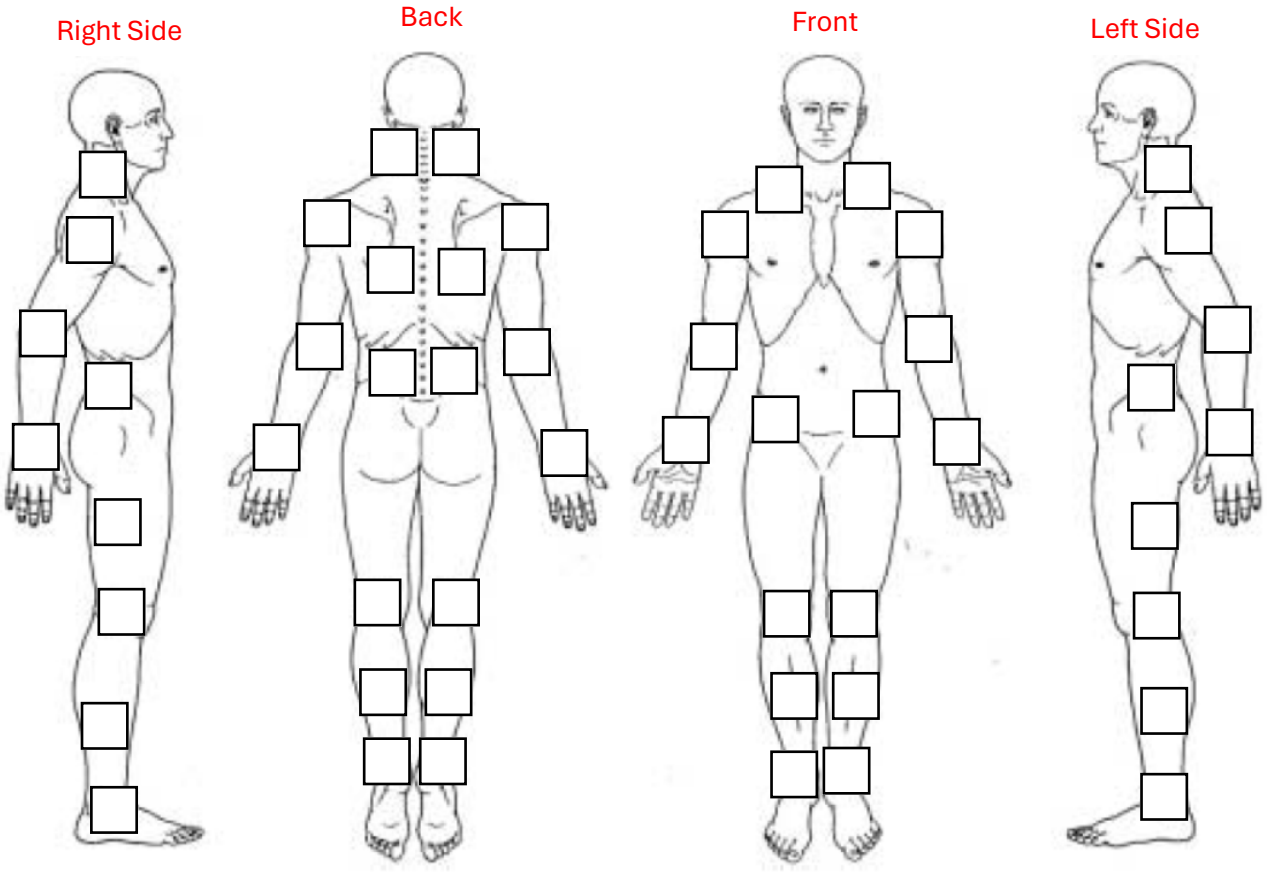
Date of Surgery (if surgery was performed): _____

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).

PAIN SCORE 0-10 Numerical Rating Scale (NRS)





Have you fallen 2 or more times in the past 2 years WITH Injury? ☐ Yes ☐ No

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

I have not fallen in the past 2 years. ***Initials***: _____