Chesapeake Bay AQUATIC PHYSICAL THERAPY

Initial Evaluation Date:	Therapist:
Initial Evaluation Time:	Location:
Account #:	

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
First Name:	MI:	Last Name:	
DOB:	Gender:	Marital Status:	
Address:		City, State, Zip:	
Phone (H):	Phone (C):	Ok to text? ☐Yes ☐No	
Email Address:			
Legal Guardian or Guarantor Information*: ***If the patient is a minor, please enter the address for the legal guardian or guarantor*			
First Name:	MI:	Last Name:	
DOB:	Gender:	Relationship to Patient:	
Address:			
Phone (H):	Phone (C):	Ok to text? ☐Yes ☐No	

MEDICAL INFORMATION - *This section must be completed*	
Part of the Body:	
Injury Due to:	
Date of Injury/Surgery/Symptoms:	
Referring Physician:	Phone:
Primary Care Physician:	Phone:
Next Appointment Date:	
Have you had or are you currently receiving HOME HEALTH CARE or THERAPY/CHIRO elsewhere in the current year? ☐**Yes** ☐**No**	
If yes, where:	Discharge Date:

INSURANCE INFORMATION	
Primary Insurance:	Phone:
ID/Policy#:	Group #:
Claims Mailing Address:	
Subscriber Name:	Subscriber DOB:
Secondary Insurance:	Phone:
ID/Policy#:	Group #:
Claims Mailing Address:	
Subscriber Name:	Subscriber DOB:

☐ **WORKERS COMP or AUTO CLAIMS ONLY** ☐	
Insurance Carier Name:	Claim#:
Nurse Case Manager:	Phone:
Adjuster's Name:	Phone:
Employer's Address:	Employer's Phone:

PREFERRED CONTACT METHODS

Preferred Contact Method: ☐ ***Text (preferred*** ☐ ***Phone*** ☐ ***Email (must be provided above)***

Do you give us permission to leave a message? ☐Yes ☐No

CONSENT TO TREAT AND ASSIGNMENT OF BENEFITS - *All Patients Must Initial to Be Treated*

_____ **Consent to Treatment:** I hereby consent to evaluation and treatment by my Physical Therapist at Chesapeake Bay Aquatic & Physical Therapy (CBAY)

_____ **Assignment of Benefits:** I authorize payment of my insurance benefits directly to Chesapeake Bay Aquatic & Physical Therapy for all services I receive.

CONSENT TO RELEASE INFORMATION:

I hereby authorize Chesapeake Bay Aquatic & Physical Therapy and any of its affiliate's permission to discuss my financial account and/or my therapy treatment with the following individual other than myself:

1. Name: _____ Phone:_____ Relationship to patient: _____

2. Name: _____ Phone:_____ Relationship to patient: _____

HIPAA ACKNOWLEDGEMENT - *All Patient Must Initial One Of The Following:*

_____I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices

_____I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices, but decline to accept it at this time

CANCELLATION /NO SHOW POLICY & LATE ARRIVALS (initial)

_____ **Cancellation/No Show Policy:** I understand that if I must cancel or re-schedule an appointment that I must provide at least 24 hours' notice. A $50 fee will be accessed for all missed appointments without at least 24 hours' notice. Insurance will not cover this charge. I understand that I will be responsible for a $50 fee for any cancel or no show without 24 hours' notice.

_____ **Late Arrivals:** I understand that CBAY respects the time of all patients. If I am delayed and arrive late for my appointment, understand I may be asked to wait or reschedule my appointment.

FINANCIAL AGREEMENT (sign)

1. CBAY staff will contact my insurance company and verify my physical therapy coverage. My insurance company will be billed as a courtesy, but this does not release me from financial responsibility for my account. Benefits given are not a guarantee of payment; they are dependent on my individual plan coverage. It is my responsibility to know and understand my coverage and benefits. I will contact the member services department of my insurance to verify what service(s) are covered.
2. Throughout my course of treatment, my insurance company will be billed daily. CBAY's policy is to collect copayments and coinsurances at the time of service. Some co-insurance estimates are based upon my insurance company's current fee schedule and therefore are subject to change. This may result in a small balance due or refund due after all of my claims have been processed. I understand that I am responsible for all balances during treatment and if my account balance exceeds $100, I must make payment arrangements (payment plan) or treatment may be held until payment can be made in full.
3. I will periodically receive a statement regarding my account. I will ensure that CBAY has my most current demographic and insurance information at all times. I will review my statement to ensure my insurance company is processing claims in a timely manner.
4. I am responsible for meeting my deductible, if applicable. I will be responsible for paying this amount before my insurance company begins to pay.
5. Most insurance companies require either a prescription or referral. I am responsible for obtaining updated prescriptions and referrals.

FINANCIAL AGREEMENT CONTINUED (sign)

6. If my account becomes delinquent, I understand that I may be contacted by phone in order to bring my account up to date. I also understand that if my account becomes 90 days past due, my account information may be sent to an attorney for collections. If my check is returned from the bank, I will be billed a $35.00 service charge.
7. I am responsible for notifying CBAY of any changes in my health or billing information. CBAY 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 the charges incurred for services rendered at CBAY to the extent the law allows.

Signature of Patient or Responsible Party	Relationship to Patient	Date

SUMMARY OF BILLING PROCEDURES ***(check appropriate box and sign)***

☐ **COMMERCIAL INSURANCE:** I am responsible for my co-payment, co-insurance, and any outstanding deductible that may be due. CBAY will bill my insurance company and make every effort to collect on my claim. I remain responsible for any and all fees not paid by insurance, outside of contractual adjustments made by my insurance company.

☐ **WORKER'S COMPENSATION:** CBAY will bill my WC carrier for services rendered and I will not be responsible for any payments as long as long as a valid authorization is on file.

☐ **MEDICARE:** Medicare will pay for 80% of allowable charges after the $257 deductible for Part B services has been met. In 2008, Medicare established a cap on physical therapy and speech and language pathology services. As a result, Medicare will only pay a soft cap amount of $2,410 for all of these services combined. All PT claims exceeding $3,000 may be subject to medical review. As a courtesy to me, CBAY will bill my secondary insurance to recover the additional 20% and/or deductible. If I do not have secondary insurance or if they do not pay, I will be responsible for the additional 20%, and/or deductible. Medicare also requires my physician to certify a plan of care (POC) every 30 days. After my initial visit and every 30 days thereafter, CBAY will send a POC to my physician for his/her approval and signature. While CBAY will do their best to ensure they receive this from my physician, I am ultimately responsible to ensure proper authorization is obtained for my care. Failure of my physician to authorize care **may result in a hold in treatment until the proper certification is received.**

☐ **MVA:** CBAY will bill my automobile insurance for services rendered. If benefits become exhausted, CBAY will bill my primary health insurance. At that point, guidelines for commercial insurance, as stated above, will be followed. If I do not have medical insurance, I will be responsible for payment.

☐ **MEDICAID**: CBAY will bill my Medicaid policy for services rendered and I will not be responsible for any payment as long as my policy is in good standing. If my policy is terminated for any reason during my course of treatment, I will be responsible for payment.

☐ **VCCP**: CBAY will bill the VA for services rendered and I will not be responsible for any payments as long as a valid authorization is on file.

Signature of Patient or Responsible Party	Relationship to Patient	Date

POOL POLICIES AND PROCEDURES (initial as appropriate)

1. Appointments must be scheduled for aquatics by phone or in person.
2. Pool patients must enter through the main office and sign in before proceeding to the pool.
3. Pool patient must be ready to enter the pool **AT the scheduled appointment time.** Do NOT enter the pool until instructed by the therapist.
4. Patients must EXIT the pool at the end of the treatment session. ("Pool" members have access as their membership dictates.)
5. Proper swimming attire must be worn (no cotton shirts or shorts) and patients must bring their own towel.
6. The pool facility and the Health Department require everyone to take a shower prior to entering the pool.
7. Do NOT use deodorant, lotions or powders prior to entering the pool.
8. Patients must be able to independently enter and exit the pool unless they have a Caregiver to assist them in transfers to and from the pool.
9. Open wounds or infections are NOT permitted in the water. Notify the therapist if a wound or incision has changed in any way
10. Bladder and fecal incontinence prohibits participation in aquatic treatment.
11. Only "Pool" members may use the Hot Tub or Main Pool.
12. Patients must follow all safety, health and COVID policies initiated by the "Pool".
13. Some locations may allow you to place your valuables in one of the lockers in the locker rooms. The patient is responsible for all valuables.

**"Pool" is defined as any aquatic space used by CBAY including Brick Bodies, SportFit, Fairlands Aquatic Center, Kids First Swim School. Please see the pool policies for the facility in which you are attending.

_____ **I understand and agree with all of the aquatic policies of Chesapeake Bay Aquatic & Physical Therapy and "Pool" facility**.

PHOTO/VIDEO/MEDIA RELEASE (optional)

I grant full ownership and copyright- of all photographs and or video produced within this session to Chesapeake Bay Aquatic & Physical Therapy along with the right to reproduce any of the images (and by any means chosen).

I am also in agreement that any licensee or assignee in legal correspondence with Chesapeake Bay Aquatic & Physical Therapy can use the photographs in any way and in any medium including website and social media.

The photographer, licensee(s) and/or assignee(s) hereby obtain the rights to use the photographs under no restrictions whatsoever for whatever purposes, including advertising, with any post-processing or manipulation within reason.

I agree that any of the above-mentioned photographs or manipulations used by the photographer, licensee(s) and/or assignee(s) to represent an imaginary person shall not reflect upon me personally unless I give legal permission to use my full name.

I commit to withdraw from making any legal claims or disputes against either the photographer or his/her agents in regard to image usage and understand fully that the photographer is under **no legal obligation to compensate me** for the use of any photo(s).

I understand all meanings and implications that have been explained to me in writing and I agree to all terms as described above.
**If the model is under the age of 18, the below signature is one of a parent or legal guardian.

Signature of Patient or Responsible Party	Relationship to Patient	Date

Chesapeake Bay AQUATIC PHYSICAL THERAPY

CBAY would like to know how you found us! *Please check off the category (in bold) and subcategory that best describes how you discovered Baltimore PT to start your PT journey. You do NOT need to sign this sheet. It simply provides helpful information to our marketing department. Thank you for your participation!!*

☐ **DOCTOR CATEGORY**:

Primary Doctor sent you here directly: ☐ Name of Doctor: _____

Specialist sent you here directly: ☐ What type of specialist? _____

Name of Doctor: _____

Doctor sent you to Physical Therapy but not directly to us: ☐

You chose us from a list of therapy companies provided at the Doctor office: ☐

☐ **INSURANCE CATEGORY**:

You called your insurance company, and they referred you to us: ☐

Type of Insurance: _____

☐ **INTERNET**:

You saw us on:

Google/or other search engine: ☐ Facebook: ☐

Instagram: ☐ Twitter: ☐ Website: ☐

Story or newsletter about us: ☐ Other: _____

☐ **SELF-REFERRAL**:

You were a previous patient here and are now returning: ☐

☐ **COMMUNITY**:

You saw our clinic or sign in the community: ☐

Fair/Event: ☐ Seminar: ☐

☐ **OTHER REFERRAL SOURCE**:

You were referred by:

Attorney: _____ Personal Trainer: _____

Gym Worker: _____ Friend/Family Member: _____

Patient First:_____ Other urgent care:_____

Other: _____

Chesapeake Bay AQUATIC & PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone#: _____ Referring MD: _____

Primary MD: _____ Weight/Height (to obtain BMI):____

Please indicate if you have or had any of the following services: **When/Where:**

- Physical Therapy _____
  - Discharge date? _____
- Chiropractic Services _____
  - Discharge date? _____
- Home Medical Services _____
  - Discharge date? _____

Please indicate if you have or had any of the following: **Describe:**

- Pregnancy _____
- Heart Problems _____
- Uncontrolled Blood Pressure _____
- Diabetes _____
- Asthma _____
- Pace Maker/Defibrillator _____
- Current/Active Infection _____
- Open Wound _____
- Active Cancer _____
- History of Cancer _____

- Night Sweats _____
- Osteoporosis _____
- Surgery _____
- Depression/Anxiety _____
- Seizure Disorder/Epilepsy _____
- Allergy to Tape/Latex _____
- Recent Unexplained Weight Loss/Gain _____
- Uncontrolled Bowel or Bladder Function _____
- Catheter _____
- Falls in the Past 12 months _____
- Injury as a result of falls _____

Do you have any current or past restrictions from any of your doctors? ☐YES ☐NO

Please list your restrictions: _____

List ALL Current Medications including name; dose; how delivered (i.e. orally, injection); how often taken. Please include dietary supplements, vitamins, OTC medicines, and any herbal or alternative substances:

_____

_____

_____

Have you had a fall assessment performed over the last 12 months: ☐YES ☐NO

Do you currently Exercise: ☐YES ☐NO How often/Where?_____

Do you belong to a gym/club/group for exercise: ☐YES ☐NO

Would you be interested in a Wellness Program? ☐YES ☐NO

Patient Signature: _____ Date:_____

Guardian for patient under 18: _____ Relationship: _____ Date: _____

POLICIES AND PROCEDURES FOR AQUATIC THERAPY PATIENT COPY

Thank you for choosing Chesapeake Bay Aquatic & Physical Therapy for your aquatic therapy needs. In order to make your therapy sessions run as smoothly as possible, please review our policies and procedures below.

PLEASE:

1. Schedule or reschedule your appointments with our receptionists by phone or in person.
2. Enter through the main office and sign in before proceeding to the pool, **even if you have a club membership.** This procedure helps us to keep track of when you come to your appointments.
3. Once you sign in at the front desk, you may proceed to the pool. The aquatic therapist will be waiting at the pool.
4. In order to make sure that you receive full treatment time, we ask that you arrive at your appointment early enough to sign in, change in the locker room (if needed) and **enter the pool at your treatment time.** Patients arriving early for their appointment may be asked to wait until their appointment time to enter the pool.
5. **Wear appropriate swimming attire** (no cotton shirts or shorts allowed) and please bring a towel with you at every appointment.
6. The pool facility and the Health Department require everyone to take a shower before entering the pool.
7. Please refrain from using deodorant, lotions or powders prior to entering the pool.
8. Patients must be able to independently enter and exit the pool unless they have a Caregiver to assist them in transfers to and from the pool.

***General Information**:*

1. At certain locations you may place your valuables in one of the lockers in the locker rooms. Please contact the pool facility for additional information.
2. Aquatic therapy sessions will last approximately one hour unless stated otherwise by the therapist.
3. Open wounds or infections are NOT permitted in the water. Please let the aquatic therapist know if a wound or incision has changed in any way.
4. Bladder or fecal incontinence prohibits participation in aquatic treatment.
5. Patient must exit pool at the end of treatment session. (“Pool” members have access as their membership dictates.)
6. Only members of the pool facility are allowed to use the pool outside of their treatment time.
7. Only members of the pool facility are allowed to the Hot Tub or Main pool.

****“Pool” is defined as any aquatic space used by CBAY including Brick Bodies, SportFit, Fairlands Aquatic Center and Kids First Swim SchooL. Please see the Pool Policies for the facility in which you will be using.**