BALTIMORE
PHYSICAL AQUATIC & SPORTS THERAPY

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

## PATIENT REGISTRATION FORM

| | | | |
|---|---|---|---|
| * | ***PATIENT INFORMATION*** | | |
| | Patient Name: | | |
| | First: | MI: | Last: |
| | DOB: | Gender: | Marital Status: |
| | Legal Guardian or Guarantor Information: | | |
| | First: | MI | Last: |
| | DOB: | Gender: | Relationship to patient: |
| | ***If the patient is a minor, please enter the address for the legal guardian or guarantor*** | | |
| | Address: | | City, State, Zip: |
| | Phone 1: | Phone 2: | Text: Y / N |
| | Email Address: | | |
| * | ***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 currently having HOME HEALTH or THERAPY/CHIRO elsewhere in the current year? Y / N** | | |
| | 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 Name: | | Claim: |
| | Nurse Case Manager / Adjusters Name: | | Phone: |
| | Employer's Address: | | Employer's Phone: |
| | ***PREFERRED CONTACT METHODS (circle)*** | | |
| | Preferred Contact Method (circle): | ***Text (preferred)*** ***Phone*** | ***Email (must be provided above)*** |
| | Do you give permission for us to leave a message? Y / N | | |
| * | ***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 Baltimore Physical Aquatic & Sports Therapy (Baltimore PT) | | |
| | **Assignment of Benefits:** I authorize payment of my insurance benefits directly to Baltimore Physical Aquatic & Sports Therapy for all services I receive. | | |

* ***CONSENT TO RELEASE INFORMATION:***

I hereby authorize Baltimore Physical Aquatic & Sports Therapy LLC and any of its affiliates permission to discuss my financial account and/or my therapy treatment with the following individual other than myself:

Name: Relationship to patient:

Name: 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.

* ***FINANCIAL AGREEMENT (sign)***

1. Baltimore PT 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. Baltimore PT's policy is to collect copayments and co-insurances 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 Baltimore PT 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 will begin to pay.

5. Most insurance companies require either a prescription or referral. I am responsible for obtaining updated prescriptions and referrals.

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 Baltimore PT of any changes in my health or billing information. Baltimore PT 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 Baltimore PT 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. Baltimore PT 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:** I pay nothing out-of-pocket as long as my carrier pre-authorizes treatment.

☐ **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, Baltimore PT 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, Baltimore PT will send a POC to my physician for his/her approval and signature. While Baltimore PT 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:** I understand Baltimore PT does not accept MVA injuries at this time and that Baltimore PT cannot bill my medical insurance for an auto accident unless I have waived my PIP (Personal Injury Protection) and can provide Baltimore PT with a PIP waiver from my auto insurance carrier.

☐ **LITIGATION:** If my treatment is related to an injury or accident that involves legal proceedings, Baltimore PT's policy is to not wait for settlement or payment. Therefore, I am responsible for payment at time of service.

**Signature of Patient or Responsible Party** **Relationship to Patient** **Date**

**

***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 Baltimore PT respects the time of all patients. If I am delayed and arrive late for my appointment, I understand I may be asked to wait or reschedule my appointment.

*

***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 Baltimore PT including Merritt Clubs. Please see the pool policies for the facility in which you are attending.

**I understand and agree with all of the aquatic policies of Baltimore Physical Aquatic & Sports 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 Baltimore Physical Aquatic & Sports 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 asignee in legal correspondence with Baltimore Physical Aquatic & Sports Therapy can use the photographs in any way and in any medium including website and social media.

The photographer, licensee(s) and/or asignee(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 asignee(s) to represent an imaginary person shall not relect 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 regards 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 the 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** |
|---|---|---|

***Baltimore PT would like to know how you found us!*** *Please check off the category (in bold) and sub-category 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: _____

Specialist sent you here directly:_____ what type of specialist? _____

Name of Doctor: _____

Doctor sent you to PT but not directly to us: _____

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

**OTHER REFERRAL**:
You were referred by:

Attorney: _____ Personal Trainer: _____

Gym Worker: _____ Friend/Family Member:_____

**INSURANCE CATEGORY**:
You called your insurance company and they referred you to us: _____

Type of Insurance: _____

**SELF-REFERRAL**:
You were a previous patient here and are now returning: _____

**INTERNET**:
You saw us on:

Google/or other search engine: ____ Facebook: ____

Instagram: _____ Twitter: ____ Website: _____

Story or newsletter about us: _____ Other: _____

**COMMUNITY**:
You saw our clinic or sign in the community:_____

Fair/Event: _____

Seminar: _____

**OTHER REFERRAL SOURCE**:
Patient First:_____ Other urgent care:_____

**OTHER:** _____

BALTIMORE
PHYSICAL AQUATIC & SPORTS 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 Baltimore Physical Aquatic & Sports 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.
8. Patients must follow all COVID policies initiated by the "pool".

**"Pool" is defined as any aquatic space used by Baltimore PT including Merritt Clubs. Please see attached Pool Policies for the facility in which you are using.