

East Valley Physical Therapy & Aquatic Rehabilitation
 217 South 63rd Street, #101
 Mesa, AZ 85206
 Voice: 480.981.0900 Fax: 480.981.0897

Patient Registration Form

Ins. Carrier:		Therapist:		Account#:	
Name:		DOB:		Age:	
Address:			City, ST, Zip Code:		
Home Phone:		Work Phone:		Cell:	
Sex:	SSN:		Patient Marital Status:		
Permanent Address:			City, ST, Zip Code:		
Referring Physician:					
Reason for Today's visit?			E-mail address:		
Was this a job related or auto accident? Yes No			Date of Accident: / /		
Is patient being treated pregnant? Yes No			How did you hear of us?		

Emergency Contact Information

Name:	Phone:	Relationship:
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Insurance Information

Primary Ins.:		MemberID:		Group#:	
Insured Name:		DOB:		Sex:	
Insured Employer:		Insured SS #			
Employment Status: [] Employed [] Retired					
Secondary Ins.:		MemberID:		Sec. Group#:	
Insured Name:		DOB:		Sex:	
Employment Status: [] Employed [] Retired					

CELL PHONE USE IS NOT PERMITTED IN THE CLINIC

Authorization to Release Information: I hereby authorize **East Valley Physical Therapy & Aquatic Rehabilitation** to release medical information required in the course of my examination or treatment to the referring physician, «RefProviderFirstLastName».

Signature (required): _____ Date: _____

Authorization for Payment: I hereby authorize payment directly to the business of **East Valley Physical Therapy & Aquatic Rehabilitation** for the surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for the charges not covered by my insurance.

Signature (required): _____ Date: _____

MEDICAL HISTORY

Patient Name:

Dear Patient,

In order that we might better serve you, please answer the following questions. This information is confidential and is for the therapist only. Are you currently taking prescribed medication? [] Yes [] No **If Yes, please list them in the space provided.**

Do you have allergies to medications of which we should be aware, including cortisone or adhesive tape? [] Yes [] No **If yes, please list them below.**

Have you had any medical conditions that we should be aware of during your past or current medical treatment, including but not limited to:

Diabetes []	Heart Condition []	CVA/Stroke []
Cancer []	Pregnancy []	Seizure Disorder []
Any indwelling stimulator devices :	Pacemaker []	
Dorsal column stimulator []	Pain or insulin pump []	
Other:	None []	

Family Physician Physician's Full Name: _____

Consent for Treatment

I, «**PatientFullName**» , give permission to **East Valley Physical Therapy & Aquatic Rehabilitation** to care for and treat me. Your physical therapist will explain your plan of care to you and any risks. Your alternative to treatment is to refuse without penalty or prejudice. Please ask if you have any questions regarding your treatment or if you do not understand what has been explained to you. Feel free to ask at any time during your treatments at our facility. In cases of minor children, they also have my permission to care for and treat them. I understand that my child may receive physical therapy unattended as long as I am aware of the current treatment. I understand that I will be notified if my child's treatment and/or therapy changes. _____ **(INITIALS PLEASE)**

Assignment of Benefits

I, «**PatientFullName**» , authorize assignment of benefits from any and all insurance payable for medical care rendered to myself and/or my dependents. Photocopies are valid as originals. I understand that I am responsible for any amount not covered by insurance. I also understand if my insurance does not acknowledge within 90 days the balance will be my responsibility. **Benefits quoted by East Valley Physical Therapy are not a guarantee as they only quote what the insurance quotes them.** I authorize release of my **Protected Health Information** required by insurance carriers for purposes of submitting claims and collecting payment. If any proceedings or actions shall be brought against me to recover any outstanding balance, the undersigned agrees to pay all costs and expenses acquired including reasonable attorney fees.

I am aware of the Notice of Privacy Practices, which has been given to me or posted with the office for my review. I further understand that I can request that my **Protected Health Information** be limited by requesting so in writing to the Privacy Officer. I understand that this authorization meets the needs of HIPPA (**Health Insurance Portability and Accountability Act**) guidelines set forth by the Federal Government in regards to patient confidentiality. _____ **(INITIALS PLEASE)**

Same Day Cancellation and No-Show Policy

If it becomes necessary for you to cancel or reschedule an appointment, please notify the office 24 hours in advance, when possible. We realize extenuating circumstances i.e. emergencies may occur. If repetitive cancellations or no shows occur, you will be charged a cancellation fee of \$45.00 **per occurrence** and EVPT will exercise the right as per our policies and procedures to not re-schedule any patient who cancels or no shows two or more times. The cancellation fee will be the responsibility of the patient, as most insurance companies will not compensate our practice for cancelled appointments or no-shows. We appreciate your patronage and ask your cooperation in maintaining the Cancellation and No Show Policy. Thank you.

I have read the above statement and understand it is my responsibility to call the office of East Valley Physical Therapy and Aquatic Rehabilitation at least 24 hours in advance whenever I cannot attend my appointment. _____ **(INITIALS PLEASE)**

Patient's Signature (or guardian of a minor child)

Date

GUIDELINES/RULES FOR EVPT AQUATIC REHABILITATION CENTER

Welcome to East Valley Physical Therapy's Aquatic Rehabilitation Center. We appreciate your confidence in allowing us to assist in your rehabilitation and fitness needs. We hope that your time with us will be pleasant and we will do our best to meet your therapeutic needs and goals.

In order to maintain quality and efficiency we ask that you comply with the following:

1. Always sign in at the front desk prior to entering the Aquatic Center.
2. Please shower prior to your aquatic therapy session. If you are unable to comply, we have showers and dressing rooms available. **Please limit the amount of time in the dressing room and shower as there may be others waiting.**
3. Avoid the use of oils, Lotions, or medicated creams prior to use of the aquatic center.
4. Please do not bring food or drink in the pool area. **NO CELL PHONES!**
5. Please respect the exercise areas of others so all may enjoy the benefits of aquatic therapy.
6. Be careful of wet surfaces. **FOOTWEAR IS REQUIRED WHEN WALKING BETWEEN THE DRESSING ROOM AND POOL AREA.** Walk slowly inside the pool area. Always use bars when entering or exiting the pool. **Dry off completely before exiting the pool area!**
7. **DO NOT ENTER THE POOL IF YOU ARE INCONTINENT (BLADDER OR BOWEL CONTROL PROBLEMS), CATHETERIZED, OR AN OSTOMY PATIENT.**
8. Please use the restroom prior to entering the water.
9. **DO NOT ENTER THE POOL IF YOU HAVE ANY INFECTIONS, OPEN WOUNDS, OR SORES.** If you have any questions, please check with a therapist.
10. For safety reasons, the pool area is restricted to patients and/or clients only.
11. Aquatic shoes are not to be worn directly from the street to the pool. Please carry them with you.
12. Please wear appropriate swimming attire for use of the pool. Please bring **TWO** towels.
13. Lock all valuables in the lockers provided (including hearing aids). We will not be responsible for lost or stolen items.
14. Patients or clients requiring assistance with dressing before or after using the pool **MUST** be accompanied by a caregiver who can provide assistance and bring with them any necessary adaptive dressing equipment. The caregiver should remain available within the facility in case of any unexpected problems that may occur during the aquatic session.

Thank you for your compliance.

Patient's Signature (or guardian of a minor child)

Date