Aquatic Fitness, Inc.

REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Last Name:		First Name:		Middle Initial:
Birth Date:	Social Security:		Height:	Weight:
Street address:	City:		State:	Zip:
Home Phone:	Cell Phone:		Next Appt (with referring doctor):	
Date of Injury:	How did your injury occur?			
Previous Treatment:				
Diagnostic Tests:				

MEDICAL HISTORY

Do you currently have or have you ever had any of the following? (please check all that apply)

❑ Afraid of water	❑ Chemotherapy/Radiation	❑ Gout	❑ Infectious Disease	❑ Shortness of Breath
❑ Allergies/Pool Chemicals	❑ Chronic Diarrhea	❑ Hearing Difficulties	❑ Open Wounds	❑ Sleeping Problems
❑ Angina (chest pain)	❑ Currently Pregnant	❑ Heart Attack/Problems	❑ Osteoporosis	❑ Stroke
❑ Arthritis	❑ Currently Smoke	❑ Heart Surgery	❑ Pacemaker	❑ Thyroid Problems
❑ Asthma	❑ Diabetes	❑ Hernia	❑ Pins or Metal Implants	❑ Urinary Tract Infection
❑ Bladder Leakage	❑ Dizziness	❑ High Blood Pressure	❑ Psychological Problems	❑ Weight Loss
❑ Blood Clot	❑ Emphysema	❑ Joint Replacement	❑ Scoliosis	❑ Other (list)
❑ Bowel Leakage	❑ Fibromyalgia	❑ Kidney Problems	❑ Severe Headaches	
❑ Cancer	❑ Frequent Fainting	❑ Knee Problems	❑ Seizures/Epilepsy	

Have you ever had an injury or surgery on any of the following?

	Injury	**Surgery**		**Injury**	**Surgery**		**Injury**	**Surgery**
Foot:	❑	❑	Back:	❑	❑	Elbow:	❑	❑
Ankle:	❑	❑	Hand:	❑	❑	Shoulder	❑	❑
Knee:	❑	❑	Wrist:	❑	❑	Neck:	❑	❑

List any other specific medical history:		
List all surgeries in the past 2 years:		
Have you fallen in the past year? ❑ Yes ❑ No	If yes, how many times?	Were you injured? ❑ Yes ❑ No
List current medication with dosage (Including prescription, OTC, herbals, vitamins/supplements):		
Name of Employer:	Time at Employer:	Job Title/Description:
Are you presently working? ❑ Yes ❑ No	❑ Light Duty ❑Full Duty	Hours per Day: / Last Day of Work:
List any Restrictions:		
What is your vocational goal or your personal goal for therapy?		
Describe your pain Symptoms/Locations/Type		

Pain Scale (Circle One):	**Least**	0	1	2	3	4	5	6	7	8	9	10	**Most**

What makes your symptoms worse?	
What makes your symptoms better?	
Functional/Mobility Limitations?	Is there an attorney involved? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name :	Relationship to Patient:	Home Phone:
Patient/Guardian signature:	Date:	

I hereby certify that all information provided by me to Aquatic Fitness is correct and complete and hereby give my consent for evaluation and or/treatment to Aquatic Fitness to be administered by persons in it's office in acceptable professional standards.

I also authorize Aquatic Fitness to release any information requested regarding services rendered to me by Aquatic Fitness, Including medical records to any third party payer or treating or consulting physician or medical care provider. This authorization shall remain in effect for 36 months from this date unless sooner revoked by me in writing.

I will also advise Aquatic Fitness staff if there are any changes in my physical condition that would alter my performance in this program. I agree to abide by all posted and otherwise mentioned rules and regulations of Aquatic Fitness.

WORKERS COMPENSATION INSURANCE

I hereby authorize _____Insurance Company to pay by check, made out and mailed directly to Aquatic Fitness, Inc. all and any benefits due me from any indemnity provisions under terms of my policy or other compensatory coverage to which I may be entitled.

Payment is authorized upon receipt of any and all itemized statements for services rendered to me. The policy was in full force and effect at the time that any services were rendered by Aquatic Fitness on my behalf. Payment of any amounts as herein directed, in whole or part, shall be considered the same as if paid by the company directly related to me. This is a direct assignment of my rights and benefits under any policy related to me. A photocopy shall be considered as effective and valid as an original.

I authorize the release of any medical records necessary to process my claims.

Patient/Guardian Signature:	Date:

PRIVATE HEALTHCARE INSURANCE

The following information was given to Aquatic Fitness on _____ from the below mentioned insurance company. This information is not a guarantee of payment. (date)

I understand that it is my responsibility to check any and all insurance benefits prior to my visits at Aquatic Fitness, Inc. I acknowledge that payment is due at the time of treatment. I accept full financial responsibility and am aware that Aquatic Fitness is no responsible to any charges not covered or denied by my insurance company. I understand that I am responsible for the charges incurred. In the event that I fail to pay these charges, I will be responsible for reasonable collection costs associated with the cost of resolving my account.

Insurance Company:							
Effective Date:		Co-Pay :		Deductible:		Deductible Met:	
# of Visits:		Visits used:		Patient Responsibility:			
Secondary Insurance Company:							
Patient/Guardian Signature:				Date:			

NOTICE OF PRIVACY ACKNOWLEDGEMENT

Missouri State University Health Care Components are required by law to maintain the privacy of protected health information and to provide individuals with notice of it's legal duties and privacy practices with respect to Protected Health Information (PHI)

I, _____hereby acknowledge that Aquatic Fitness, Inc has offered me The Notice of Privacy Practices Policy (effective 4/14/2003) and there is a copy available in the office for me to read.

Patient/Guardian Signature:	Date: