**Oaks Shopping Center**
**1570 Egypt Road, Suite 120**
**Phoenixville, PA 19460**
**Telephone: 610-676-0411**
**Fax: 610-676-0412**

## Patient Consent

I, ______________________________, consent to receive treatment at AquaSport Physical Therapy. I understand that all charges incurred by me for services rendered are my responsibility. I assign all of my third party insurance benefits (including Medicare) to be paid to AquaSport Physical Therapy on my behalf. If it is necessary for an outstanding balance to be referred to a collection agency, I understand all collection fees and interest will be my responsibility.

Client Signature: ____________________________________ Date: _______________________

Parent / Guardian: __________________________________

## HIPAA Privacy Regulations

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of December 2000 with modifications in August 2002, the staff of AquaSport Physical Therapy is required to inform you of the following information about your rights of privacy:

- At times it is necessary for AquaSport Physical Therapy to release your medical information to your physician, case manager, or insurance company;
- The purpose of sharing this information may include such things as pre-certifying your care, co-coordinating your care with other medical providers, or obtaining payment for services;
- Your permission to release your medical information to the above mentioned agents will expire when you are discharged from care and your account is paid in full;
- You have the right to revoke your authorization without bias.

Client Signature: ____________________________________ Date: ________________________

Signature of authorized agent: _________________________ Relationship: _________________

**Circle any of the conditions below that you have experienced or been diagnosed with by your physician:**

| | | | | |
|---|---|---|---|---|
| Cancer | Osteoporosis | Anemia | Diabetes | Hepatitis |
| Ulcers | AIDS/HIV | Polio | Seizures | |
| Fainting/Dizziness | | | | |
| High blood pressure | Hemophilia | Gout | Thyroid | Concussion |
| Chest pain | MS | Tuberculosis | Fibromyalgia | Hernia |
| Guillain-Barre | Bronchitis | Pneumonia | Stroke | Allergies |
| Asthma | Emphysema | Migraines | Depression | Parkinson's disease |
| Kidney disease | Blood clot | Frequent falls | Shortness of breath | Arthritis: osteo or rheumatoid |
| Bowel/Bladder issues | Urinary tract infection | Cardiovascular disease | | |
| Other ________________________ | | | | |

**Have you had any of the following procedures in relation to CURRENT condition?**

| | | |
|---|---|---|
| X-ray | Injection(s) | EKG or stress test |
| CT scan or MRI | Blood test(s) | Biopsy |
| Bone scan | Nerve conduction study | Surgery |
| Physical therapy | Chiropractic therapy | Emergency room |

**Please list any medications you are currently taking (prescription and/or over the counter):**

**Please list any additional information that would assist us in providing care to you:**

**Please rate your pain on a scale of 0-10 at best and at worst (0=no pain 10=medical emergency):**

| | |
|---|---|
| Today: At Best _____ | Over the past week: At Best ______ |
| Today: At Worst ____ | Over the past week: At Worst _____ |

**Are you currently pregnant: _____Yes _____No _____ N/A**

**Medicare Patients:** Have you had **ANY** home health care within the past 30 days? Yes _____ No______

_________________________________ _________________________________

**Patient Signature** **Date**

**PATIENT REGISTRATION**

DATE: ___/____/_____

PATIENT NAME: ______________________________________________________________
Last First Initial

ADDRESS: __________________________________________________________________
Street Apartment

__________________________________________________________________
City State Zip Code

TELEPHONE: ________________________________________________________________
Home Cell Work

E-MAIL: _____________________________________________

DATE OF BIRTH: ___/____/____ SOCIAL SECURITY #: ____________________SEX: M / F

IS CONDITION RELATED TO:

AUTO ACCIDENT? Y / N DATE OF ACCIDENT: _________________

WORK ACCIDENT? Y / N DATE OF ACCIDENT: _________________

DATE OF INJURY OR SURGICAL DATE: ______________________________________

WHO IS YOUR FAMILY DOCTOR? ___________________________________________

WHAT DOCTOR REFERRED YOU TO PT? _____________________________________

HOW DID YOU HEAR ABOUT AQUASPORT? ___________________________________

EMPLOYER:________________________________________________________________

EMERGENCY CONTACT:_____________________________________________________
Name Relationship Phone