Welcome to Southern California Aquatic and Physical Therapy!

Thank you for choosing our team to be your partner in your recovery success. We provide *World Class Service* for all of your rehabilitation needs. It is our goal to work with you and your medical team to offer you an individualized treatment plan to promote the best possible outcome.

The new patient information packet is designed to collect the information necessary to begin our partnership. Please bring the completed and signed forms along with your prescription, insurance card, photo identification and any other pertinent medical records. If you cannot provide current insurance information and we cannot verify coverage, you may need to reschedule your appointment or make payment in full for the Initial Evaluation.

Physical therapy services provided are determined by different factors including Physical Therapist Evaluation and Treatment Plan, physician orders, condition, and insurance benefits. Additional services are available on a cash basis.

Please dress in comfortable clothing providing your Physical Therapist access to areas of treatment. This may include shorts and/or a tank top. Please do not wear a dress. Pool attire is not required for your first visit unless you are notified prior to the appointment.

24-hour notice is required if you are unable to keep your scheduled appointment.

If you have any questions before your visit, please contact our friendly staff at **(714) 375-1755**. Our office is located at **16271 Beach Blvd, Huntington Beach CA 92647** next to the comfort suites.

We look forward to being partners in your recovery success!

In great health,
Julie Bergmann, PT, OCS, Owner

Southern California
Aquatic and Physical Therapy

The Bridge to Wellness
Serving California Since 1995

Patient Registration Form

Patient Name: ____ Male_____ Female _____
First Middle Last

Address: ________________________________ City: _______________ State: ______ Zip: __________

Home Phone: _________________________________ Cell Phone: _______________________________

Birthdate: ______/ ______/ __________ Age: ________

Email Address: ____

Driver's License/I.D. #: _______________________ Social Security Number: _________________________

Employer: ______________________ Occupation: __________________ Phone: ____________________

Single: ____ Married: ____ Spouse Name: _________________________ Widowed: _____ Divorced: _____

Referring Physician: __________________________ Phone Number: ______________________________

Address: ________________________________ City: ________________ State: ______ Zip: _________

Primary Care Physician: ____________________________ Phone Number: _________________________

Address: ________________________________ City: ________________ State: ______ Zip: _________

Are you being seen for a work or auto accident related injury? ______ Yes ______ No

Date of Injury: _____________ Date of Surgery: ____________

Have you treated with us in the past? _____ Yes ______ No

How did you hear about us? ____
(ex: Friend, doctor, Goggle, etc..)

In case of Emergency who may we contact? (Please list 2)

1) Name of Emergency Contact: ____

Relationship to you: _________________ Phone Number: ___________________

2) Name of Emergency Contact: ____

Relationship to you: _________________ Phone Number: ___________________

In case of Emergency requiring 911 Services, what is your preferred hospital?

____

I authorize Southern California Aquatic and Physical Therapy to release any medical information necessary to process any claims that are pertinent to my medical care.

By signing below, you certify that the above information is true and correct to the best of my knowledge.

_______________________________	X_____________________________	___________________
Patient Name	Patient Signature	Date
X______________________________	___________________	
Staff Signature	Date	

Patient Medical History

Patient Name:____ Date:__________________

Height: __________feet, __________inches Weight: __________ pounds

Are you on a weight loss program (Yes / No): If yes, please describe:

____

____

____

Did you participate in a regular fitness program prior to your injury? (gym, walking, fitness classes, etc.)

____

Are you able to continue? (Yes / No)

The following questions pertain to your **CURRENT** medical condition:

Date of Injury/onset of symptoms: __________________

Please circle: Chronic New injury Surgery Work injury MVA

Date of Surgery: _______________ Type of Surgery: ____

Please describe how you were injured / how your condition began:

____

____

____

Answer the following pertaining to your **CURRENT** medical condition:

X-Rays: Date: ___________ Body part: ____

MRI: Date: ___________ Body part: ____

Other diagnostic tests:

____

____

Patient Name:____ Date:__________________

Have you had any prior treatments for this injury? (Yes / No) If yes, describe:

____

____

What is your Primary Concern/Chief Complaint?:

____

____

____

What daily activities have been limited by your present condition? (Be specific):

____

____

____

Do you currently use an assistive device to walk with? (Yes / No) If yes, describe:

____

What are your activity goals? (return to gardening, return to work, return to gym, etc.)

____

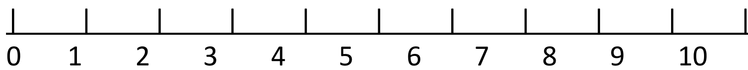
____

____

Pain Rating

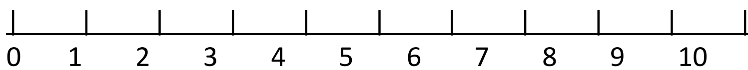
If you have pain, what is your current pain level? (0 = no pain, 10 = extreme pain)

Pain level at **WORST** (circle)



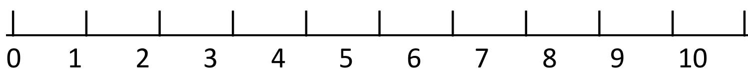
0 1 2 3 4 5 6 7 8 9 10

CURRENT Pain Level (circle)

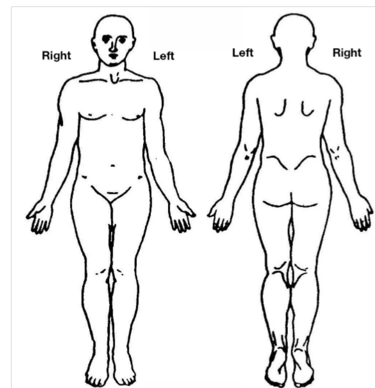


0 1 2 3 4 5 6 7 8 9 10

Pain level at **BEST** (circle)



0 1 2 3 4 5 6 7 8 9 10



Hand Dominance:

Left Right

Patient Name:____ Date:________________

Describe your symptoms to the best of your ability (numbness, tingling, pins and needles, etc.)

____

____

What makes your pain better?

____

What makes your pain worse?

____

Who do you live with? (circle) alone with spouse/partner with family other:______________

Have you fallen in the past 12 months? (Yes / No) If yes, how many times?

____

Occupation / Work Status

Current occupation:__________________________________ Work Status: ____________________

Date last worked:______________________ Date return to work:______________________

Describe required physical work duties:

____

____

____

How would you classify your general health? (circle): Good Fair Poor

Medical History:

- □ Alzheimer's
- □ Cardiovascular Disease
- □ Cerebral Vascular Accident
- □ Current Infection
- □ Diabetes Mellitus Type 1
- □ Diabetes Mellitus Type 2
- □ Fibromyalgia
- □ Fracture or Suspected Fracture
- □ High Blood Pressure
- □ Other ________________
- □ History of Cancer
- □ Huntington's
- □ Immunosuppression
- □ Lupus
- □ Muscular Dystrophy
- □ Obesity
- □ Osteoarthritis
- □ Parkinson's
- □ Rheumatoid Arthritis
- □ Traumatic Brain Injury

Are you a smoker? (Yes / No) If yes, how much do you smoke per day?

____

Do you have a history of depression and/or anxiety? Are you receiving treatment?

____

Please list all medications including herbals/vitamins: (if you have a list, please provide):

____

____

____

Please list any past surgical procedures:

____

____

To the best of my knowledge, I have fully informed Southern California Aquatic and Physical Therapy of my health history and current problem information and status.

________________________________	X______________________________	___________________
Patient Name	Patient Signature	Date

X______________________________	___________________
Physical Therapist Signature	Date

Informed Consent/Release and Agreement

Physical Therapy involves the use of many different types of physical evaluation and treatment. At Southern California Aquatic and Physical therapy, we use a wide variety of procedures, modalities and aquatic therapy to assist you in your recovery success.

Response to physical therapy intervention is individual. It is not always possible to accurately predict your response to a therapeutic intervention. We cannot guarantee that our treatment will help the condition you are seeking treatment for. There is a risk your treatment which may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist about your plan of care you will be receiving. You have the right to discuss with your physical therapist potential risks and benefits of a specific treatment in your plan of care. You also have the right to decline any portion of your treatment at any time during your treatment session. Should you feel any discomfort or pain associated with your treatment, it is your responsibility to discuss this with your physical therapist so that appropriate changes can be made to your plan of care.

If you should have any medical conditions that require monitoring before, during or after your treatment session as determined by your physical therapist, you must adhere to this recommendation to continue with your treatment. This may include blood pressure, heart rate, blood sugar and oxygen saturation. Monitoring is part of your plan of care and treatment time.

If your physical therapist determines your condition is not appropriate and your participation in would be dangerous to your health, you may not participate in your treatment session. Therapeutic exercises and/or aquatic therapy exercises are an integral part of your recovery success at Southern California Aquatic and Physical Therapy and has inherent risks associated with it.

I acknowledge that my treatment plan of care has been explained by Southern California Aquatic and Physical Therapy and all of my questions have been answered to my satisfaction. I understand the risk associated with physical therapy and agree to fully cooperate, participate and comply with the established plan of care. I understand my insurance policy restrictions and limitations may affect my plan of care. I wish to proceed with my physical therapy program.

______________________	X______________________	______________
Patient Name	Patient Signature	Date

Rules and Regulations for Participation in Aquatic Therapy Program

Thank you for choosing Southern California Aquatic and Physical Therapy for your aquatic therapy rehabilitation. For your safety and assistance in making your session run as smoothly as possible for you, other clients and our staff, please review and adhere to the rules and regulations below:

1. **Please arrive early** enough to be in the pool area promptly at your appointment time. This is in consideration for your treatment, other scheduled clients and our staff. If you arrive late, your treatment may have to be modified to accommodate the clinic schedule.
2. **Mandatory Pool Attire:** Pool shoes, non slip rubber shoes to be worn at all times on pool deck, hallways and bathrooms. Conservative swim wear material only, no cotton or natural materials.
3. **Caution on all pool deck surfaces, hallways and bathrooms**. No crutches allowed on pool deck. You will be provided with a walker when needed. No personal assistive devices in pool area allowed.
4. **Courtesy toward other therapy clients.** We are all here to share the same great aquatic experience. We have the right to refuse any person's treatment displaying any inappropriate behavior towards another client or staff member.
5. **Rinse off prior to entering pool** and dry off as much as possible prior to leaving pool deck before entering rest rooms. Please leave restroom free from standing water. If you need assistance, we are happy to help you.
6. **Bring your own towel and water bottle to stay hydrated**. Lockers are provided for your personal items.
7. **Caretakers, Family members, Children** (must be accompanied by an adult) wait in reception area until your pool session is completed.

General Information

Participation is aquatic therapy is **not permitted** with the following conditions: open sores, wounds, infections of any kind, uncontrolled bowel/bladder incontinence, elevated blood pressure, decreased lung capacity or oxygen saturation levels less than 96%, uncontrolled seizures, uncontrolled heart conditions, uncontrolled blood sugar. Participation is dependent upon your Physical Therapist approval and medical condition.
I have read and understand the rules and regulations and inherent risks involved to participate in the aquatic therapy program. I will notify a staff member immediately if I have any change in my medical condition that may affect my ability to participate in the aquatic therapy program. I agree to abide by all of the above.

______________________	X______________________	______________
Patient Name	Patient Signature	Date

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Acknowledgement of Receipt of HIPAA Privacy Notice

I have read and acknowledge the HIPAA Privacy Notice of Southern California Orthopedic and Aquatic Therapy.

______________________________	X______________________________	____________________
Patient Name	Patient Signature	Date

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Client Financial Responsibility Policy

____________________________________, **"Client"** it is client responsibility to know and understand client insurance benefits and responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Be sure to carry your health insurance card, doctors, hospitals, or other health care providers want to see your card when you need health services.

- INSURANCE COVERAGE - Client insurance policy is a contract between "client" and insurance provider. As a courtesy, Southern California Aquatic Therapy will file client claim. However, the client is required to provide Southern California Aquatic Therapy with current, correct and updated information about their health insurance policy, and will be responsible for any charges incurred if the information provided is not accurate or up-to-date. Client Financial Responsibility includes any inaccurate **Third Party** information collected.

- APPOINTMENTS – **24 hours** notice must be provided in the event client cannot keep an appointment. Should client not provide this notice; a cancellation fee of $50 may then be added to your account.

- CO-PAYMENTS – By law Southern California Aquatic Therapy MUST collect your carrier-designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. We accept Personal Checks, Cash, Visa, MasterCard, and American Express only. Should client not pay at the time of service and we subsequently send client a statement, an administrative fee of $20 may be added to your account.

- OUT OF NETWORK PLANS – Client will be responsible for any balance their health insurance plan indicates as due on their explanation of benefits (EOB) form. Southern California Aquatic Therapy will adjust the charges to coincide with client's healthcare plan UCR (Usual, Customary and Reasonable) charges. All clients will be responsible for their co-insurance and deductible. If Southern California Aquatic Therapy does not 'participate' with clients health plan, we will send a courtesy bill to that carrier on client's behalf. However, should carrier not pay client claim within 45 days; client will be responsible for the full amount due. Should client receive payment from your insurance carrier, please forward payment to Southern California Aquatic Therapy office.

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of medical benefits to Southern California Aquatic Therapy for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. **Initial: ___________**

- SELF-PAY CLIENTS – Payment is expected at the time of service unless financial arrangements have been made prior to clients visit. We accept Personal Checks, Cash, Visa, MasterCard, and American Express only. **Initial: ___________**

- "MINORS" PARENTS OF MINOR CLIENTS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Southern California Aquatic Therapy will not be involved with separation or divorce disputes. **Initial: ___________**

- **MEDICARE** – We will submit claims to Medicare. The client will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you provide verification of one. Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Southern California Aquatic Therapy for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits. **Initial: ___________**

- **IDENTITY PROOF and VERIFICATION –** Clients must provide ID. To change or create a new enrollment, the primary client's identity must be verified. Client will need to show a document (or documents) that will prove your identity. There are many different kinds of proof of identity that you can use, including your driver's license. The visual proof of identity process requires either one photo ID or two vital statistic documents without a picture to prove identity.

Clients are responsible for the timely payment of their account. Should it become necessary for Southern California Aquatic Therapy to use an outside agency to collect payment, client will be additionally held responsible for any secondary charges incurred.

We are committed to providing Clients with the best possible care and are pleased to discuss Southern California Aquatic Therapy professional fees with clients at any time. Client's clear understanding of our Financial Policy is important to our professional relationship. If clients have any questions regarding fees, financial policy or client financial responsibility, clients are encouraged to ask our friendly staff for help.

________________________________	X______________________________	____________________
Patient Name	Patient Signature	Date