Lakeway Aquatic Physical Therapy
P.O. Box 342348, 900 Ranch Road 620 South, Ste. A103, Lakeway, TX 78734
Phone: 512-261-0620, Fax: 512-261-9441, www.lakewayaquatics.com

Patient Information

Date: _____ Referring MD: _____ Family MD: _____

Last Name: _____ First Name: _____ M.I._____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home #:_____ Cell #:_____ E-Mail:_____

Date of Birth: _____ Age: _____ Marital Status: M ___ D ___ S ___ W___

Spouse or Guardian Name: _____

Emergency Contact:_____ Phone #:_____

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PAST MEDICAL HISTORY

Name: _____ Date: _____

Date of Injury/Onset: _____ Describe injury/condition: _____

Have you been treated for this before? No Yes If yes, when: _____

Do you or have you had any of the following:

	Have	Had	NA		Have	Had	NA
Osteoarthritis				Fibromyalgia			
Rheumatoid Arthritis				Osteoporosis			
Cardiac Issues				Ringing in Ears			
Diabetes Type 1				Urine Leakage			
Diabetes Type 2				Bladder Problems			
Allergies				Bowel Problems			
Surgery				Breathing Problems			
Psycho-Social				Gallbladder Problems			
Dementia				TB			
History of Cancer				Liver Disease			
Current Infection				Kidney Problems			
Immunosuppression				Infectious Diseases			
Fractures				HIV			
Smoking				Stroke			
Dizziness/Fainting				Seizures			
Nausea/Vomiting				Skin Abnormalities			
Headaches				Other Complicating Factors			

If you answered yes to any of the above conditions, briefly explain with onset date. Include any other pertinent information regarding your past medical history: _____

_____

_____

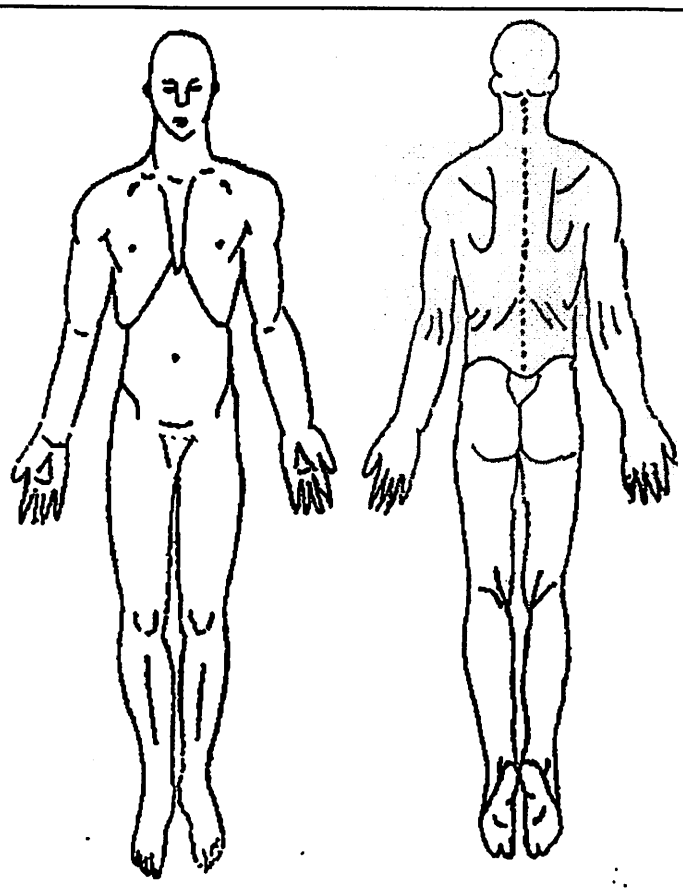
Please list all medications you are taking:

Medication name	Dosage	Frequency	Administration route (oral, injection, topical etc)	For what condition.

Please circle the areas where your symptoms are located and circle intensity of pain for each area
(see Functional Pain Scale below)

Functional Pain Scale

0	No Pain ----------	No pain or limitation in activity
1-2	Mild Pain ----------	Annoying - pain is present but does not limit activity
3-4	Mild/Mod pain ---------	Nagging, uncomfortable – can still do most activities with rest periods
5-7	Mod Pain ----------	Miserable/ Distressing – Unable to do some activities because of pain
8-9	Mod/Severe ----------	Intense/ Dreadful – Unable to do most activities because of pain
10	Severe Pain----------	Unbearable/ Worse possible – Unable to do any activities - hospitalization



Area 1 – _____

At Worst (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

Current (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

At Best (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

Area 2 – _____

At Worst (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

Current (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

At Best (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

Area 3 – _____

At Worst (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

Current (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

At Best (**within last week**) 0-1-2-3-4-5-6-7-8-9-10

Consent to Treatment

I understand that I have been referred for physical therapy treatment and care to the Lakeway Aquatic Therapy & Wellness Center. I understand that I have the right to ask and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan prescribed for me. By signing this agreement, I consent to have Lakeway Aquatic Therapy & Wellness Center provide treatment and care as prescribed by my physician and/or recommended by my therapist.

_____ _____

Patient's Signature Date

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ASSIGINMENT OF BENEFITS

PRIVATE INSURANCE PATIENTS

You are responsible for any co-payment, co-insurance or deductible at the time of service. If your plan requires prior authorization to see a specialist, **you are responsible** for getting the insurance referrals from your primary care physician **before** the appointment for an evaluation. We highly recommend that you read your insurance policy or contact your insurance company regarding your physical therapy benefits. Insurance is a contract between you and your insurance company regarding your benefits, and it is your responsibility to understand your coverage. **We will not debate your insurance coverage**.

MEDICARE & SECONDARY INSURANCE PATIENTS

I understand that Medicare will be billed for my services at Lakeway Aquatic Therapy & Wellness Center. I also understand that Medicare will pay 80% of the allowed amount. I will be responsible for the deductible (if not already met) and the non-covered charges. I will not be responsible for the non-allowed charges.

I request that payment of authorized Medicare and secondary Medicare benefits be made on my behalf to Lakeway Aquatic Therapy & Wellness Center for any services furnished to me by that provider of care.

If you are currently under the care of a Home Health Agency or any other physical therapist, Medicare will not pay for your treatments at Lakeway Aquatic Therapy & Wellness Center. Therefore, you will be responsible for all charges until you are discharged from the Home Health Agency or from another physical therapist.

Are you currently under the care of a Home Health Agency? **Yes ____ No____**
Are you currently under the care of another Physical Therapist? **Yes ____ No____**
Have you had outpatient physical therapy services this year? **Yes_____ No____**

ALL PATIENTS

I hereby authorize my insurance and/or worker's compensation benefits to be paid directly to **Medley Swim Systems Inc. dba Lakeway Aquatic Therapy & Wellness Center.** I understand that I am financially responsible for non-covered services. I understand and agree that regardless of my insurance and/or worker's compensation status, I am ultimately responsible for the balance of my account for professional services rendered.

I authorize any holder of medical information about me to release to the billing department and its agents any information needed to determine these benefits or the benefits payable for related services. I also authorize **Medley Swim Systems Inc. dba Lakeway Aquatic Therapy & Wellness Center** to release any information to process claims.

_____ _____
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CONSENT & DESIGNATED INDIVIDUALS AUTHORIZATION

I have received, read, and fully understand Lakeway Aquatic Therapy & Wellness Center's *Notice of Information Practices*. I understand that Lakeway Aquatic Therapy & Wellness Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Lakeway Aquatic Therapy & Wellness Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to use and disclosure of my personal health information for purposes as noted in Lakeway Aquatic Therapy & Wellness Center *Notice of Information Practices*. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

DESIGNATED INDIVIDUALS AUTHORIZATION

Should I decide to have other individuals involved with my therapy, the designated parties as listed below by me may receive information regarding my treatment and/or payment of treatment received at Lakeway Aquatic Therapy & Wellness Center.

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

GENERAL LIABILITY CONSENT

I understand that Lakeway Aquatic Therapy & Wellness Center, its staff, and members cannot be held liable for any injuries while on premises or otherwise under the supervision of its staff. I assume all responsibility and waive any claim for compensation for accidental injury while under instruction, supervision, or control of Lakeway Aquatic Therapy & Wellness Center, Inc. I hereby release, indemnify, and hold harmless Medley Swim Systems Inc. dba Lakeway Aquatic Therapy & Wellness Center and its agents, employees, or servants from any damage or property damage suffered to me or my minor child because of our participation in any activities. I agree to adhere to all swimming pool & spa rules and understand that there is no lifeguard on duty.

_____ _____
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CANCELLATION AND NO-SHOW POLICY

Showing up as scheduled is one of your most important responsibilities.
The following are our policies regarding cancellations and no-shows:

- **We require 24 hours notice in the event of cancellation.**
- **There is a $30.00 charge for a cancellation without proper notification that will not be covered by your insurance and you will be responsible to pay at the appointment following your cancellation.**

The following may be examples of why you feel you should not attend your scheduled therapy appointment and are not considered legitimate reasons for canceling:

- You are feeling worse and think the treatment is not working.
- You are feeling better and do not feel you need to come in for a treatment.
- If you are in pain, come in and we can help to decrease the pain you may be experiencing.
- If you are not experiencing any pain, now is the time that we can start to progress your treatment to address some of the underlying causes of your problem and to educate you so you do not re-injure yourself.
- Your social calendar is more important than your healthcare.

When a patient does not show up for their scheduled appointment three people lose:

- You, the patient, because you are not getting the needed treatment as prescribed by your doctor/therapist.
- The therapist who now has an empty space in their schedule since that time was reserved for you personally.
- Another patient who could have been scheduled to receive treatment if there had been proper notice.

Please cooperate with us in this regard and we will have you out of pain and feeling better soon. We are looking forward to working with you! Thank you.

I understand and agree to comply with the Cancellation and No-Show Policy.

_____ _____

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Falls Efficacy Scale

Name _____

Date _____

On the scale from 1 to 10, 1 being very confident and 10 being not confident at all,
How confident are you that you can do the following activities without falling?

Activity	Score 1 very confident 10 not confident at all
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals not requiring carrying heavy or hot objects	
Get in and out of bed	
Answer the door or telephone	
Get in and out of chair	
Getting dressed and undressed	
Personal grooming (i.e. washing you face)	
Getting on and off the toilet	

(A total score of greater than 70 indicate that the person has a fear of falling.) Total Score: _____

How many times in the past year did you fall? _____

Did you injure yourself from any fall? _____

How often does it happen that you think you are about to fall but manage to grab something and then don't fall? _____

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Nitro Swimming

Waiver/Release of Liability

Please read carefully before signing.
This is a release of liability and waiver of certain legal rights.

I,_____, the participant and/or the parent/guardian of the participant agree and understand that swimming is a HAZARDOUS activity. I recognize that there are risks inherent in the sport of swimming, including but not limited to paralyzing injuries and death.

The participant hereby agrees to indemnify and hold harmless Nitro Swimming / Splash Swimming, it's coaches, officers, directors, agents and employees against any liability resulting from any injury that may occur to the participant while participating in activities at the Nitro Swim Center. The participant also agrees to indemnify Nitro Swimming / Splash Swimming for any damages incurred arising from any claims, demand, action or cause of action by the participant.

The participant authorizes any representative of Nitro Swimming / Splash Swimming to have the participant treated in any medical emergency during their participation at the Nitro Swim Center. Further, the participant and/or parent/guardian agrees to pay all costs associated with medical care and transportation for the participant.

I have noted any medical/health problems on the back of this form.

I HAVE CAREFULLY READ THE ABOVE LIABILITY RELEASE AND SIGN IT WITH FULL KNOWLEDGE OF ITS CONTENTS AND SIGNIFICANCE.

Signed: _____ Date: _____
Participant or Parent/Guardian

Signed: _____ Date: _____
Participant or Parent/Guardian

Participant's Name (print): _____

Organization's Name (print): LAPT