SHREVEPORT
AQUATIC & LAND THERAPIES

PERSONAL INFORMATION

First Name:_____ MI:_____ Last Name:_____

Address:_____ City: _____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Social Security #:_____ Birthdate: _____ Age:_____ Sex: M F

Occupation:_____ Employer's Name:_____

Work Address:_____ City:_____ State:_____ Zip:_____

Marital Status:_____ Spouse's Name:_____ # of Children:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

How were you referred to us?_____

INSURANCE INFORMATION

Primary Insurance Company:_____ I am the policy holder: (Circle one) Yes No

Secondary Insurance Company:_____ I am the policy holder: (Circle one) Yes No

If yes, skip the Policy Holder Information Section and provide a copy of the current insurance card to Shreveport Aquatic & Land Therapies. If no, complete Policy Holder Information Section below and provide current insurance card to Shreveport Aquatic & Land Therapies.

POLICY HOLDER INFORMATION *(If other than self)*

Policy Holder Name:_____

Relationship to patient: (Circle one) Parent Spouse Self *(if secondary insurance)*

First Name:_____ MI:_____ Last Name:_____

DOB: _____/_____/_____ SSN: ___ ___ ___ - ___ ___ - ___ ___ ___

Address:_____ City:_____ State:_____ Zip:_____

Phone: Home:_____ Cell:_____ Work:_____

Employer's Name_____; Phone #:_____ Contact:_____

Address:_____ City:_____ State:_____ Zip:_____

Please provide a copy of your driver's license and insurance card. Thank you.

Parent's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

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ASSIGNMENT OF BENEFITS / AUTHORIZATIONS

FINANCIAL RESPONSIBILITY

I have requested services from Shreveport Aquatics and Land Therapies, LLC ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider.

I certify that the health insurance information I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles. I acknowledge that Provider may not be a network provider on my insurance plan. I have either called my health insurance plan for an explanation of my benefits with regard to the services to be rendered by Provider, or I have elected not to do so. I understand that I can contact Provider's billing office directly during Provider's operating hours with any questions regarding my financial responsibility for the services to be rendered by Provider.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Provider to:

(1) release any information necessary to my health benefit plan (or its administrator) regarding my condition and treatments;

(2) process insurance claims generated in the course of treatment; and

(3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

INFORMED CONSENT TO ENGAGE IN ELECTRONIC MAIL COMMUNICATION

I hereby consent to have Provider, communicate with me via e-mail regarding such services received from Provider. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between Provider and me regarding my services may be intercepted by third parties or transmitted to unintended parties. Should confidential information regarding such services be improperly disclosed through no fault of Provider, Provider will not be liable for such disclosures. By signing below, I agree that Provider is not liable for improper disclosures of my and/or my dependent's protected health information and/or breaches of confidentiality caused by me (i.e., printing or forwarding e-mails), third parties or technical factors beyond Provider's control. I also agree that if I send an e-mail that invites a response, and one is not given with a reasonable timeframe, it is my responsibility to notify Provider of the e-mail. I will not assume that because it was not returned, that it was received. E-mail shall not be used for urgent, emergent or other time-sensitive situations. I understand that in an urgent or emergent situation, I should call 911 or go to the Emergency Room and not rely on e-mail. For questions regarding email, I can call Provider's office at: (318) 383-0022.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient:_____ Date:_____

Policyholder:_____ Date:_____

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PATIENT RESPONSIBILITIES

We strive to provide you the best personalized care available. To make this possible we ask that you comply with the following guidelines:

- You agree to arrive, dressed for the right environment (gym/pool) and at the scheduled time.
- You agree to comply with your treatment plan as prescribed by your physical therapist, including:
- Showing up for all your visits each week.
- Showing up ready for the right environment.
- Performing your home exercises as prescribed to you.
- Performing and/or adjusting any other daily or nightly activities that you are asked to alter.

We have had amazing success with our patients due to the fact that they comply with their treatment plan, show up for their visits and come ready. If you have any concerns, time or financial restrictions, please bring them to our attention so that we can figure out how to handle the situation. We will work with you to help integrate physical therapy into your life's schedule, so that we can resolve your issue.

The front desk office is only responsible for collecting moneys due to the clinic and scheduling the patients in compliance with their plan of care. They cannot change treatment plans, including number of visits per week that you attend, the number of visits planned for your treatment or even the environments that you are to be treated in for each visit. All such questions must be directed to your caregivers.

By signing below or submitting this form, you are stating that all your questions have been answered, so that you completely understand what is expected of you during your treatment at our facility. By signing below you are also declaring that you understand your physical therapist may conclude your treatment at our facility at any point in time if you do not comply with all the responsibilities within this agreement.

Patient Name (print):_____ Date: _____

Patient Signature: _____

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INFORMED CONSENT FOR REHABILITATIVE THERAPY SERVICES

I,_____, hereby request and consent to rehabilitative therapy services provided by a therapist employed by Shreveport Aquatic & Land Therapies, LLC ("the Clinic") and prescribed by my physician. I understand that the rehabilitative therapy services provided at the Clinic include physical therapy, occupational therapy, and aquatic therapy. My physician has prescribed physical therapy, and I will be receiving this therapy from _____ [Name of Therapist].

I understand and agree to the following:

- My participation in rehabilitative therapy services is strictly voluntary.
- The benefits of rehabilitative services may include: gains in flexibility, strength, agility, and endurance.
- Rehabilitative services may have some risks, including: exacerbation of my symptoms or injury to me.
- I may choose to not participate, or to limit my participation, in any exercise or activity recommended by my therapist at any time.
- Exercises and activities involved in the provision of rehabilitative therapy services may be uncomfortable. I agree to maintain the level of participation in such exercises and activity recommended by my therapist. I further agree that I will immediately notify my therapist if any exercise or activity is causing me pain.
- I will advise my therapist of any changes in my physical or mental health prior to participation in each therapy session.
- My therapist is available to answer any questions or concerns that I might have regarding my participation, activities, or safety.
- I will seek further direction or explanation from my therapist of anything that I do not fully understand, or that causes me concern.
- I will comply with the instructions from my therapist about performing such exercises or activities at home, and will not attempt to engage or engage in any exercise or activity outside of my therapy sessions against my therapist's advice.
- I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition with the therapist and ask him/her any questions that I have concerning my rehabilitative services.
- I have reviewed the attached description of potential risks and benefits and hereby acknowledge my understanding of such potential risks and benefits. Based on such review and having been provided with the opportunity to ask questions about such potential risks and benefits, I am agreeing to the terms of this Informed Consent.

I acknowledge that I am signing this document of my own free will, with full knowledge of the risks being assumed.

Signature_____ Date _____

Printed Name of Patient or Legal Guardian _____

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CONSENT FOR APPEALS

I, _____ , (patient name) allow Shreveport Aquatic and Land Therapies to file my claims, process and appeal my claim for services rendered for my physical therapy services. I allow them to execute an appeal form on my behalf as referenced this executed document for further processing.

Patient Signature _____

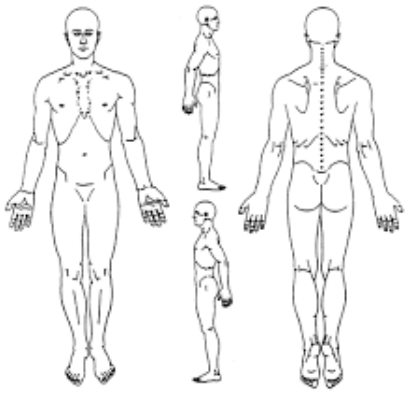
Medical Questionnaire – Physical Therapy

Patient Name:_____ Date of Birth:_____ Age: _____

Occupation:_____ Employer:_____ Hrs/Wk: _____

What problem or diagnosis brings you here today? _____

Side of Injury: ☐ R ☐ L Describe how your injury occurred: _____



Shade your areas of pain or discomfort.

Please rate your pain on the scale below from 0 to 10:

(0 = no pain; 10= worst pain imaginable/emergency pain)

Pain at rest:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain with activity:
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What is the frequency of your pain? ☐ Constant ☐ Intermittent

Does your pain wake you at night?_____ How many times?_____

What eases your symptoms?_____

What aggravates your symptoms?_____

Are your symptoms ☐ Better ☐ Worse ☐ Same? Is your pain worse in the ☐ AM ☐ PM ☐ Mid-Day?

Are you currently working on ☐ Light duty ☐ Normal duty? Is this a motor vehicle claim? ☐ Yes ☐ No

What activities at home, work or recreational are you unable to perform? _____

Have you had a similar condition before? ☐ Yes ☐ No If yes, when _____

Have you had any tests for this condition? ☐ Yes ☐ No If yes, when_____

Check tests: ☐ X-Rays ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ Nerve Tests ☐ Blood Tests ☐ Other

Have you had any other treatment for this condition? ☐No ☐Yes

If yes, what kind? ☐ PT ☐ OT ☐ Chiropractor ☐ Massage

Current level of physical activity: ☐ High ☐ Medium ☐ Low List:_____

What goals do you hope to accomplish in Physical Therapy?_____

_____

Medical History (Check all that apply)

☐ Angina/ Chest Pain	☐ Cancer	☐ Hearing Problems	☐ MRSA
☐ Asthma	☐ Depression	☐ Heart Disease	☐ Osteoporosis
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Pacemaker/Nitroglycerin
☐ Blackouts	☐ Diverticulitis	☐ High Blood Pressure	☐ Poor Circulation
☐ Blindness	☐ Ear Infections	☐ High Cholesterol	☐ Polio
☐ Blood Clot	☐ Endometriosis	☐ Hypoglycemia	☐ Seizures
☐ Bowel problems	☐ Fibroids	☐ Menopause	☐ Stroke
☐ Carpal Tunnel	☐ Fibromyalgia	☐ Migraine Headaches	☐ TB
☐ Fractures	☐ Major Spinal Injury	☐ Frequent Falls	☐ Coronary Disease
☐ Bladder problems	☐ Abdominal Surgery	☐ Chest Surgery	☐ Traumatic Injury
☐ MVA			

Are you pregnant? ☐ Yes ☐ No

Do you have a history of whiplash or low back pain? ☐ Yes ☐ No If so when/how long?

Do you smoke tobacco? ☐ Yes ☐ No If yes, how much? _____ How long?_____

Medications/Allergy/Surgeries

List current medications_____

List allergies & surgeries _____

Patient printed name _____

Patient signature _____Today's Date _____

Complete Back of this Page

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Fear-Avoidance Beliefs Questionnaire (FABQ)
Waddell et al (1993) Pain , 52 (1993) 157 - 168

Here are some of the things which other patients have told us about their pain. For each statement please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect *your* pain.

	Completely disagree			Unsure			Completely agree
1. My pain was caused by physical activity.....	0	1	2	3	4	5	6
2. Physical activity makes my pain worse.....	0	1	2	3	4	5	6
3. Physical activity might harm my back.....	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse.....	0	1	2	3	4	5	6

The following statements are about how your daily job duties or housework affects or would affect your pain

	Completely disagree			Unsure			Completely agree
6. My pain was caused by my work or by an accident at work.....	0	1	2	3	4	5	6
7. My work aggravated my pain.....	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain.....	0	1	2	3	4	5	6
9. My work is too heavy for me.....	0	1	2	3	4	5	6
10. My work makes or would make my pain worse.....	0	1	2	3	4	5	6
11. My work might harm my back.....	0	1	2	3	4	5	6
12. I should not do my normal work with my present pain.....	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain.....	0	1	2	3	4	5	6
14. I cannot do my normal work till my pain is treated.....	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to that work.....	0	1	2	3	4	5	6

Scoring
Scale 1: fear-avoidance beliefs about work – items 6, 7, 9, 10, 11, 12, 15.
Scale 2: fear-avoidance beliefs about physical activity – items 2, 3, 4, 5.

Source: Gordon Waddell, Mary Newton, Iain Henderson, Douglas Somerville and Chris J. Main, A Fear-Avoidance Beliefs Questionnaire (FABQ) and the role of fear-avoidance beliefs in chronic low back pain and disability, *Pain*, 52 (1993) 157 – 168, 166.