ULTRA HEALTH
PHYSICAL & AQUATIC THERAPY

53 BRENTWOOD ROAD – SUITE B
BAY SHORE, NEW YORK 11706

Mission Statement

1. Ultra Health Physical and Aquatic Therapy is committed to providing the highest quality health care possible. While working closely with our patients' and referring physicians, we provide the opportunity for various types of procedures and modalities, and we carefully evaluate each patient to determine what will work best for you. We are committed to continuing our education on physical therapy techniques in order to provide our patients with the best care as possible.

2. Our goals are to reduce your pain, increase Range of Motion and Strength, improve your posture; educate you on proper body mechanics, and a home exercise program. After your evaluation, we will send a detailed report stating our findings and our treatment plan to your doctor.

3. It is important to follow your doctor and PT treatment plan if given a home exercise program. You must attempt to do this as this will shorten your therapy treatment and improve your progress. If your prescription says 3x a week, you should come 3x a week. Again, this will help reach your maximum potential.

4. Co-pay must be paid at every visit. Again, if your treatment calls for 3x a week you should come 3x a week. If you can not afford a 3rd co-pay or any co-pay please speak to the receptionist/therapist and we will try to make other arrangements. You should never allow a co-payment to compromise your health. Again, if there is a financial reason, talk to someone.

5. If you ever have any problems, complaints, or suggestions please do not hesitate to speak with me, Edward Kalten PT at [631] 328-5920

Thank you,
Edward Kalten PT, Director

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information please review it carefully. If you have any questions about this policy you may contact our Privacy Officer, Eddie Kalten.

ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY LEGAL DUTY

It is the legal duty of ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY to protect the confidentiality of your personal health information. We are required to provide you with this notice which outlines our policies and procedures.

USES AND DISCLOSURES OF HEALTH INFORMATION

ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY, hereafter referred to as the Practice, uses your personal health information (PHI) in order to provide treatment to you, to be able to obtain payment for your treatment, to perform administrative activities within the practice, and for being able to determine the quality of care that is provided to you. PHI is all the personal information that can identify you: your name, address, telephone number, social security number, health policy number, etc. For example, we may use your PHI to call you to remind you about an appointment or to contact your insurance company for payment, speak to your Doctor about your program, or just call you into the treatment

The practice may use your PHI without prior authorization when we are required to do so by law, if there is a public health concern, if you have a communicable disease, if we believe that there is abuse or neglect, for research studies, for legal proceedings, for law enforcement, if a crime occurs in the Practice's office, if an emergency occurs, to funeral directors and coroners, for military activity and national security, and for worker's compensation

It is policy of Metro Comprehensive Physical Therapy to get a signed authorization from you prior to releasing your PHI. You have the right to either agree or object to the release of your information. If you agree and sign a written authorization, you have the right to take back the authorization at a later date if you choose to. If you are not actually present, or unable to agree or disagree, to the disclosure of information, the Practice can then use it's professional judgment to decide if the disclosure is in your best interest.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to inspect and ask for a copy of your personal health information at any time. You have the right to ask us to make changes or corrections in your information. The Practice does not have to comply with your request. You have the right to file a disagreement with the Privacy Officer.
You may request a list of all the disclosures that we have made of your PHI after April 14, 2003 for any reason other than for treatment, billing, or administrative activities of the practice.
You also have the right to ask in writing that the Practice not disclose your PHI except when authorized by you, required by law or in the case of an emergency. You may also request that your PHI is not disclosed to family members or friends that may be involved in your care. The Practice will consider all such request, but is not required to agree or act on them. You have the right to have confidential information sent to you at an alternative location or by a means other than the postal service.You have the right to obtain a copy of this notice.

CONCERNS AND COMPLAINTS

If you feel that your privacy rights have been violated at any time or you do not agree with how your PHI is being disclosed, you can contact our Privacy Officer at the address listed below. The Practice will not retaliate against you for filing a complaint. You can also contact the Secretary of Health and Human Services.

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BAY SHORE, NEW YORK 11706
[631] 328-5920

The terms of this notice may change at any time. A copy of the revised notice will be posted in the office in easily accessible areas and will be provided to you upon your request. This notice was published on May 1, 2003 and becomes effective on April 14, 2003.

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

53 BRENTWOOD ROAD – SUITE B
BAY SHORE, NEW YORK 11706

Patient Acknowledgement of Receipt of Privacy Practices Notice

This is to acknowledge that I have received and reviewed Ultra Health Physical And Aquatic Therapy's Notice of Privacy Practices. If I have any questions, I can contact the Practice at (631) 360-2600

PRINT NAME: _____

SIGNATURE: _____

DATE: ____/___/_____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

53 BRENTWOOD ROAD – SUITE B
BAY SHORE, NEW YORK 11706

WORKERS COMPENSATION

TERMS AND CONDITIONS FOR PHYSICAL THERAPY

I understand that my Workers Compensation Insurance will be billed at the Workers Compensation prevailing rate. However, if my Workers Compensation benefits are denied I understand that I will be responsible for your private fee. There will be an increased fee if additional equipment or exercise procedures are used, e.g.: Cybex, Nautilus or Eagle. Also, there will be an increase in fee if more than one diagnosis is being treated.

I also understand that I cannot be under the care of a chiropractor while undergoing physical therapy or I am responsible for services rendered since Workers compensation considers this concurrent treatment and will not pay.

Any insurance checks issued and sent to patient for physical therapy services will be signed over to ULTRA HEALTH PHYSICAL THERAPY AND AQUATIC THERAPY. ***If insurance benefits are denied or if there is a deductible on your policy, patients are responsible for payment of services.***

Payment is to be made to this office: Ultra Health Physical and Aquatic Therapy.

If this account shall be placed in the hands of an outside attorney for collection, the Responsible Party agrees to pay all costs of collection, including reasonable attorneys' fees not to exceed 20%of the unpaid balance, together with necessary court costs and disbursements.

If you are unable to keep your appointment, please give the office 24 hour cancellation notice. If 24 hour cancellation is consistently not given, we will no longer schedule appointments in advance, and we will ask that you call for your appointment on the same day you would like to come in.

I have read the above, and agree to the terms and conditions.

Signature: _____

Date: _____/_____/_____

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157
State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604
Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645
130 Main Street W. ROCHESTER 14614 (866) 211-0644
935 James St. SYRACUSE 13203 (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ☐WCB ☐DB ☐Discrimination and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
Claimant's Name

represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

_____, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

_____.
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

_____ _____
Claimant's Signature (ink only) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

In the event I fail to prosecute the claim for workers' compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workers' compensation case, I,_____, hereby agree to pay [NAME] : ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY at

[ADDRESS]: 53 BRENTWOOD ROAD – SUITE B, BAYSHORE, NEW YORK 11706

his/her usual and customary fees for services rendered to the above named claimant in the above identified case.

Date:_____/_____/_____ Signature_____

If signed by other than claimant, print below the name, address, and relationship of signer.
Name and Address: _____

Relationship: _____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

CONFIDENTIAL MEDICAL HISTORY/EVALUATION

Name: [LAST] _____, [FIRST] _____ Date:_____/___/____
Address: _____Ph:/cell: [____]_____
Emergency Contact _____ Relationship: _____ Ph: [____]_____
Insurance Co: _____ Subscriber ID: _____Group #:_____
Insured Employer/Address: _____
Occupation: _____Is this injury: Work Related Y/N Auto Accident Y/N
Date of Injury: _____ Chief Complaint: _____
Current Limitations: _____
List any/all medications you are currently taking: _____
Are you allergic to any medications: _____
List any surgeries: _____
Have you had any diagnostic test for this Injury? MRI Results/Date _____
Other: _____ X-ray Results/Date _____

			Mild	Moderate	Severe	Unable
Asthma, Bronchitis or Emphysema	☐ Yes ☐ No	**Bending**	☐	☐	☐	☐
Shortness of Breath/Chest Pain	☐ Yes ☐ No	**Care for Infirm Family**	☐	☐	☐	☐
Coronary Heart Disease	☐ Yes ☐ No	**Carrying Groceries**	☐	☐	☐	☐
Do you have a pacemaker?	☐ Yes ☐ No	**Change Pos (Sit to Stand)**	☐	☐	☐	☐
High Blood Pressure	☐ Yes ☐ No	**Climb Stairs**	☐	☐	☐	☐
Heart Attack/Surgery	☐ Yes ☐ No	**Driving**	☐	☐	☐	☐
Stroke/TIA	☐ Yes ☐ No	**Extended Computer Use**	☐	☐	☐	☐
Blood Clot/Emboli	☐ Yes ☐ No	**Feeding (self)**	☐	☐	☐	☐
Epilepsy/Seizures	☐ Yes ☐ No	**Household Chores**	☐	☐	☐	☐
Thyroid Trouble/Goiter	☐ Yes ☐ No	**Kneeling**	☐	☐	☐	☐
Anemia	☐ Yes ☐ No	**Lift Children**	☐	☐	☐	☐
Infectious Disease	☐ Yes ☐ No	**Lifting**	☐	☐	☐	☐
Diabetes	☐ Yes ☐ No	**Pet Care**	☐	☐	☐	☐
Cancer or Chemo/Radiation	☐ Yes ☐ No	**Reading (concentration)**	☐	☐	☐	☐
Arthritis/Swollen Joints	☐ Yes ☐ No	**Self Care – Bathing**	☐	☐	☐	☐
Osteoporosis	☐ Yes ☐ No	**Self Care – Dressing**	☐	☐	☐	☐
Varicose Veins	☐ Yes ☐ No	**Self Care – Shaving**	☐	☐	☐	☐
Gout	☐ Yes ☐ No	**Sexual Activities**	☐	☐	☐	☐
Sleeping Difficulties	☐ Yes ☐ No	**Sleep**	☐	☐	☐	☐
Emotional/Psychological Problems	☐ Yes ☐ No	**Sitting (prolonged)**	☐	☐	☐	☐
Bowel or Bladder Problems	☐ Yes ☐ No	**Standing (prolonged)**	☐	☐	☐	☐
Severe/Frequent Headaches	☐ Yes ☐ No	**Walking**	☐	☐	☐	☐
Vision/Hearing Difficulties	☐ Yes ☐ No	**Yard Work**	☐	☐	☐	☐
Dizziness or Faintness	☐ Yes ☐ No	**Sports** _____				
Are you pregnant?	☐ Yes ☐ No	**Recreational Activities** _____				
Smoking **Daily**_____**Weekly**_____		**Exercise** **Daily**_____**Weekly**_____				
Alcohol Consumption **Daily**_____**Weekly**_____						

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim.

Patient /Parent/Guardian Signature: _____

Date: ____/____/_____

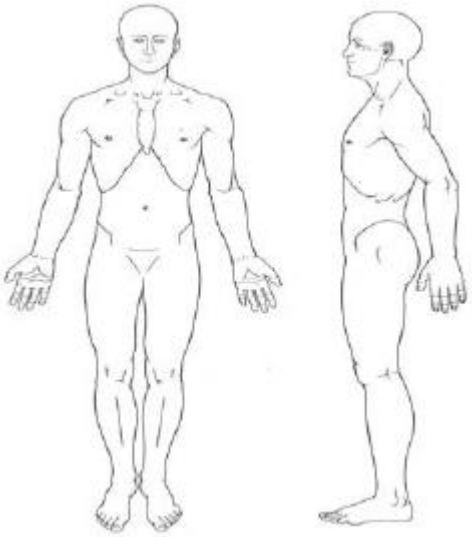
ULTRA HEALTH

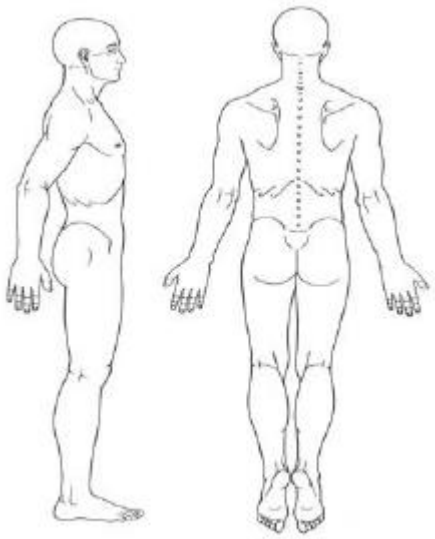
PHYSICAL AND AQUATIC THERAPY

PAIN ASSESSMENT

	10	WORST PAIN POSSIBLE, UNBEARABLE. Unable to do any activities due to pain.
	9	
	8	INTENSE, DREADFUL, HORRIBLE. Unable to do most activities because of pain.
	7	
	6	MISERABLE, DISTRESSING. Unable to so some activities due to pain.
	5	
	4	NAGGING PAIN, UNCOMFORTABLE, TROUBLESOME. Can do most activities with rest periods.
	3	
	2	MILD PAIN, ANNOYING. Pain is present, but does not limit activity
	1	
	0	NO PAIN.

Indicate where you have pain or other symptoms





PAIN ASSESSMENT LEVEL : PRESENT: _____/10, AT BEST: _____/10, AT WORST : _____/10

1. Describe your symptoms: _____

_____

a. Onset of injury: _____

b. Mechanism of injury : _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

① Sharp
② Dull ache
③ Numb
④ Shooting
⑤ Burning
⑥ Tingling

Signature: _____ ***Date:*** _____/_____/_____

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Aquatic Therapy Screen

CHECK YES OR NO IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS.

Y	N	
☐	☐	Typhoid, cholera, dysentery, or any other waterborne disease
☐	☐	Fever higher than 100 Degrees Fahrenheit
☐	☐	Kidney Disease
☐	☐	Stomach or intestinal disorder
☐	☐	Infectious disease
☐	☐	Open wounds
☐	☐	Skin rashes
☐	☐	Perforated Ear Drums
☐	☐	Incontinence
☐	☐	Epilepsy
☐	☐	Radiation Treatment within last 3 months
☐	☐	Difficulty Breathing
☐	☐	High Blood Pressure or heart disease
☐	☐	Pacemaker or Defibrillator

PRINT NAME _____

SIGNATURE _____

DATE: _____

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Physical Therapy Consent for Treatment

PROPOSED INTERVENTION/TREATMENT

- ☐ Therapeutic Exercise
- ☐ Gait Training
- ☐ Modalities
- ☐ Pool Therapy
- ☐ Patient Education
- ☐ Bed/transfer mobility
- ☐ Manual Therapy
- ☐ CPM
- ☐ Wound Care
- ☐ Other _____

POSSIBLE RISK OF HARM/COMPLICATIONS

Therapeutic exercise: sore muscles and joints
Transfers and Gait Training: fall, injury from falls.
Manual Therapy: sore joints and ligaments. Rarely, dislocation, fracture, paralysis or death.
Modalities: rash, burns, skin damage: rare, burning, periosteum.
Pool Therapy: skin irritations; rare-drowning
Wound Care: skin irritations, infection, spread of infection, increased wound size.
Other:_____

ALTERNATIVE TO TREATMENT

- ☐ Chiropractic Care
- ☐ Acupuncture
- ☐ Massage Therapy
- ☐ No treatment, resulting in possible decrease in function
- ☐ Other:_____

GOAL OF TREATMENT

- ☐ Improve mobility
- ☐ Improve function
- ☐ Improve independence
- ☐ Decrease pain
- ☐ Other:_____

Physical Therapist EDDIE KALTEN –PT

Patient Signature: _____

Date: _____/_____/_____