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.

ULTRA HEALTH
PHYSICAL AND AQUATIC THERAPY
53 BRENTWOOD ROAD –Suite B
BAY SHORE, NEW YORK 11706
[631] 360- 2600

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) 328-5920

PRINT NAME: _____

SIGNATURE: _____

DATE: ____/___/_____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

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

NO FAULT

TERMS AND CONDITIONS FOR PHYSICAL THERAPY

I understand that my No Fault insurance will be billed at the No Fault prevailing rate. However, if my No Fault 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 procedure 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 No Fault 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 AND AQUATIC THERAPY

If insurance benefits are denied or if there is a deductible on your policy, patients are responsible for payment of services (major medical insurance may be used if No Fault denies).

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:_____/____/_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*

NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH | 3. SEX | 4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

_____
(DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?
YES ☐ NO ☐ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. ☐ **(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____
PATIENT PATIENT DATE

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ **(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)**

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR

PRINT NAME _____ SIGNED _____
PATIENT (Assignor) PATIENT DATE

PRINT NAME _____ SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, X_____ ("Assignor") hereby assign to ,

(Print patient's name)

ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY("Assignee") **all rights**

(Print hospital or health care provider name)

privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _X_____, not withstanding any other agreement to the contrary.

(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THEPURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLEOR STATED CLAIM FOR EACH VIOLATION.

_____	Edward Kalten
(Print name of Patient)	**(Print name of Provider)**
_____	53 Brentwood Road-Suite B
(Address of Patient)	**(Address of Provider)**
_____	Bay Shore, NY 11706
_____	_____
(Signature of Patient) (Date)	**(Signature of Provider) (Date}**

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.

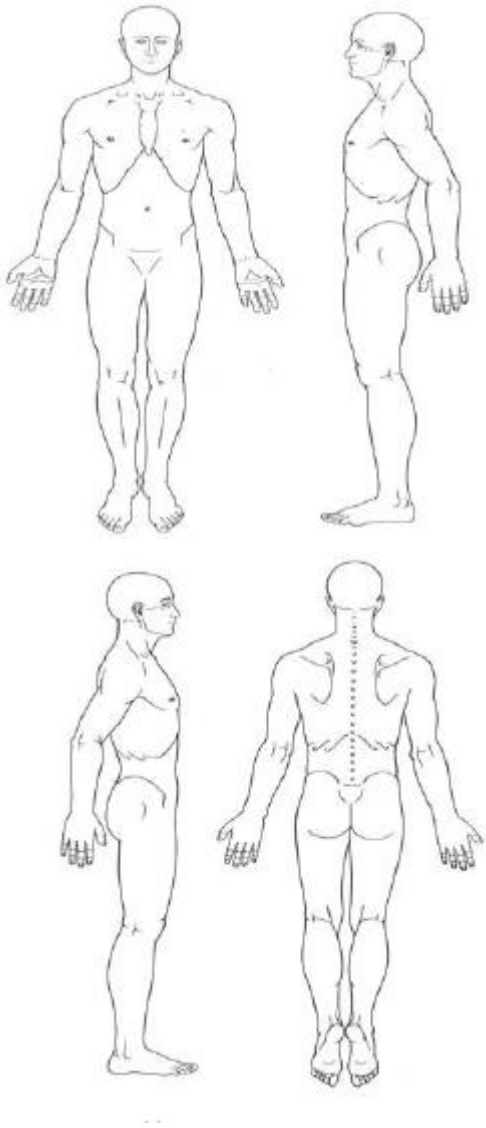
3

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 ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

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

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

53 BRENTWOOD ROAD - SUITE B
BAYSHORE, NEW YORK 11706

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: _____

ULTRA HEALTH

PHYSICAL AND AQUATIC THERAPY

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

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: _____/_____/_____