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. Self-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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[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.

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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

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TERMS AND CONDITIONS FOR PHYSICAL THERAPY
(Self Pay)

I, _____, understand the initial fee for Physical Therapy is $_50.00__. Each additional visit will be $_40.00_. There will be an increase in fee if additional equipment or exercise procedures are used, e.g.: Cybex, Nautilus or Eagle.

There will be an increase in fee if more than one diagnosis is being treated. If at any time during treatment, there is a problem with payment, e.g.: notifications of benefits denial, etc…, please notify the office manager immediately.

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 coverage does not cover Physical Therapy, patients are responsible for payment of services.***

If we are denied payment by your insurance company due to a pre-existing condition clause in your policy, you will be responsible for any unpaid balance.

Payment is to be made to this office; ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY 53 Brentwood Rd- Site B , Bay Shore – NY 11706.

In further consideration of the services rendered, I agree to waive the defense of statue of limitations in any action commenced against me to recover any sums due pursuant to this or any other agreement I may have with ULTRA HEALTH PHYSICAL AND AQUATIC THERAPY.

If you are unable to keep your appointment, please give the office a 24 hour cancellation notice.

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

Signature: _____

Date: ____/____/_____

ULTRA HEALTH

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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: ____/____/_____

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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.

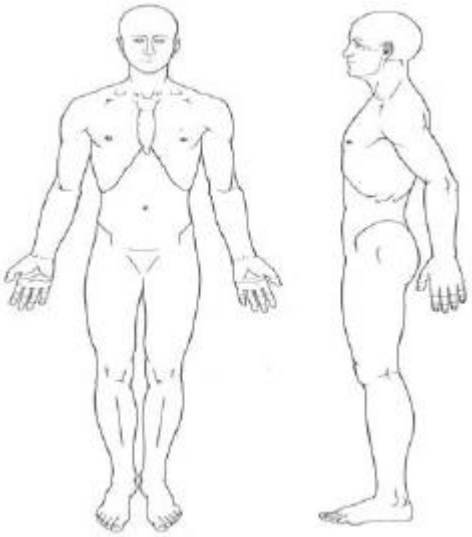
3

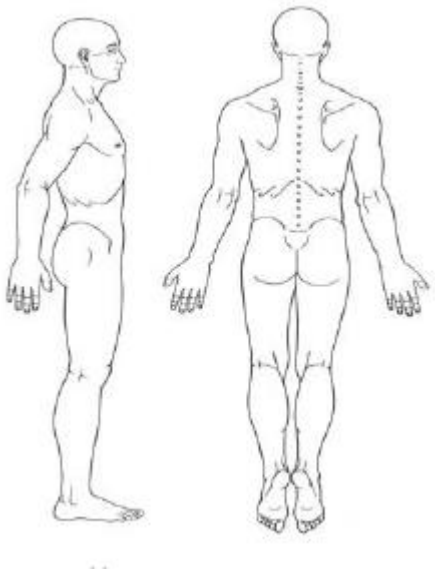
2 MILD PAIN, ANNOYING.
Pain is present, but does not limit activity

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:*** _____/_____/_____

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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: _____/_____/_____