Blue Water Therapy
916 N. Dixie Freeway
New Smyrna Beach, Florida 32168
Phone: 386-426-7885 Fax: 1-866-239-9013
bluewatertherapy1@gmail.com

Patient Registration Form

Patient Information

Date:____________________Home Phone:____________________Cell phone:____________________
Name: ____Soc Sec. No.________-________-________
Address:____DL#______________________________
City:____State:__________________Zip:_____________
Sex: □Male □Female Age:___________Date of birth:____
□Single □Married □Widowed □Separated □Divorced

Emergency Contact Information

In case of an emergency who should we contact?
Name:__________________________Home Phone:________________Cell Phone:_________________
Relationship to you?____

Primary Insurance

Insurance Company:____
Contract#_______________________Group#:_________________Subscriber#_____________________
Person Responsible for Account:____
Address(If different from patient):____
City:____State:__________________Zip:________________
Relationship to Patient:____
Birthday:_______________________________________Soc Sec No:_________-__________-__________
Person Responsible Employed by:__________________________Occupation:______________________
Business Address:_____________________________________Business Phone:____________________

Additional Insurance

Is the patient covered under additional insurance? □YES □NO
Insurance Company:_________________________________Soc Sec No:_________-_________-_________
Contract#_______________________Group#:_________________Subscriber#_____________________
Person Responsible for Account:____
Address(If different from patient):____
City:____State:__________________Zip:________________
Relationship to Patient:____
Birthday:_______________________________________Soc Sec No:__________-_________-__________
Name of other Dependents Covered Under this Policy:____
____

____________________________________ _______________________ _____________
Responsible Party Signature Relationship Date

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Medical History

Patient Name:____D.O.B______________
Name of Physician:____Phone #_______________

Are you in good health? □ Yes □ No

In the last five years have you been: (if yes, please explain)

a. Hospitalized? □ No □Yes _______________________________
b. Had a serious illness? □No □Yes________________________________
c. Had a major operation? □No □Yes________________________________

Please check the following that pertain to you:

□ Heart Surgery, Disease or Attack
□ Angina Pectoris/Chest Pain
□High/Low Blood Pressure
□ Stroke
□ Rheumatic Fever/Heart Disease
□Heart Murmur/MVP
□ Pacemaker
□ Hip Replacement
□ Kidney Disease
□ Cancer or Tumors

□ Thyroid Disease
□ Lung Disease/Tuberculosis
□ Diabetes
□

□ Surgery/Treatment Tumor/Growth
□ AIDS or HIV positive
□ Hepatitis, Jaundice or Liver Disease
□ Blood Transfusion
□ Drug Addiction/Alcoholism
□ Hemophilia or Excessive Bleeding
□ Psychiatric/Mental Disorders
□ Knee Replacement
□ Asthma
□ Sinus Trouble (Sinusitis)

□ Seizures/Epilepsy
□ Arthritis

Other:____
____
____
____

Please list all allergies or unusual reactions that pertain to you:
____
____

Patient Signature____Date:___________

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Consent to Treatment

Consent to treatment:

I hereby grant consent for treatment or services to be provided by Blue Water Therapy therapists, training staff/team.

Disclosure of Protection Health Information:

I understand that my health information is protected by federal regulations under either the Health Portability and Accountability Act (HIPPA) or the Family Educational Rights and Privacy Act of 1974 (FERPA) and may not be disclosed without my authorization or consent. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation.

I understand that my protected health information will or could be used by Blue Water Therapy staff for purposes of providing athletic training and medical services, reporting and providing information, and communication with administers, physical therapist, doctors, and other allied health professionals. Medical information shared between medical providers and all parties involved in my medical treatment along with Blue Water Therapy is confidential information and will not be shared to those outside of these positions.

I hereby consent to and authorize Blue Water Therapy health care personnel to disclose protected health information and any related information regarding any injury or illness during my treatment and participation to the individuals or entities noted above for the purposes stated above. I also consent to authorize the release of protected health information to the following listed below:(i.e. spouse, healthcare surrogate)

____

____

I also understand that the local, regional and national media are not covered by HIPAA or FERPA and these legal requirements will not apply.

______________________________ ______________________________________

Patient Signature Date Guardian Signature Date

______________________________ ______________________________________

Print Name Print Guardian Name

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Medical Records Release and Request Form

I (the undersigned) give my consent for Blue Water Therapy to request and receive any and all medical documents related to my treatment of physical therapy performed through them. I also hereby authorize Blue Water Therapy to release medical information necessary to any and all parties involved in my medical treatment (example: health care providers, insurance carriers, attorney or any other person representing me on my behalf).

____
Patient Signature or Guardian Date

____
Print Name or Guardian Date

____
Date of Birth

____
Treating Physician

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Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, auto or any other health/medical plan, to issue payment check(s) directly to BLUE WATER THERAPY INC., for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize BLUE WATER THERAPY INC., to (1) release any information necessary to insurance carriers regarding my treatments and condition; (2) process insurance claims generated in the course of examination of treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from BLUE WATER THERAPY INC. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges not covered by insurance if any incurred in the course of the treatment.

I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____
Patient/Responsible Party Signature Date

____
Witness Date

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Medication List

Medication	Dosage	Route	Frequency	Start Date

__________I am on no medications at this time. **(Please check if on no medications)**

Other:____

____

____

Patient Name:____ Date:__________________