## CANCELLATION AND NO SHOW POLICY

**Xzact Therapy** & **Aquatics** respectfully requests that any cancellations made are done with 24 hour notice. This allows us to refill your time slot with another person who needs their therapy.

**Cancellations and No Shows are a part of your medical record and will be recorded as such. More than two cancellations can result in this information being forwarded to your physician and your insurance carrier. If you are receiving Worker's Compensation, these benefits could be terminated.**

We realize your schedules are busy and we will do anything possible to accommodate your time requests and rescheduling needs. Your therapist will work with you to schedule your treatment time. If you have any special needs or concerns, please speak to the operations manager.

**Our patients are important to us. We strive to give all patients equal opportunities. We understand that emergency situations do arise but we ask that you please notify our office within 24 hours to cancel or reschedule your appointment to allow another patient to come in at that time. 3 or more cancellations within less than 24 hour notice and No-Call/ No-show appointments will be billed a charge of $20.00 to your home address.**

## REHABILITATION PROGRAM

Following your evaluation, your therapist will discuss your diagnosis, treatment program and plan as well as the potential for improvement and frequency and duration of your program. Normally, treatments can last from 30 minutes to 1 hour. Please keep your therapist informed of your next doctor visit, hopefully at least 2 days prior to the visit, so that we may retest you prior to your visit and share the results with your physician.

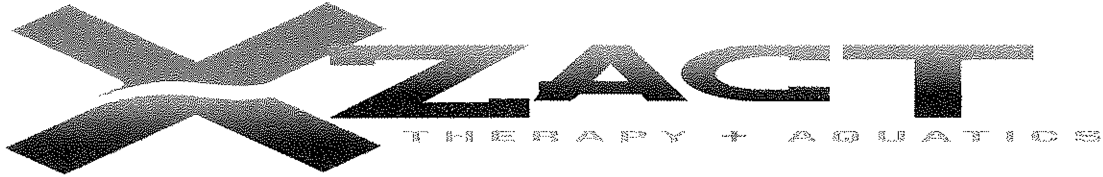
Your exercise program will be upgraded as you progress, usually each visit. You will also be given a Home Exercise Program. Both programs are vital to your success. The primary goal of the program is to decrease pain, increase flexibility, strength, and endurance, as well as general function. Another goal is to educate you and enable you to return to work, seek employment, or return to your previous level of activity.

Cold water is available during your exercise program. Please ask any staff member if you need help. No smoking or E cigs are allowed in our facility.

Infection control information includes: A biohazard trashcan is located in the whirlpool Room for discarding bandages. Sinks are located in the restrooms, and the Whirlpool Area. All mats are cleaned and pillowcases changed between each patient.

**Patients will be discharged from the program for the following reason(s): a) goals are met; b) compliance problems- exercise absences, tardiness, or lack of cooperation/poor motivation; c) lack of progress; or d) other medical complications.**

Should you ever have a concern or complaint about Advanced Therapy or your program, please notify your treating therapist. All efforts will be made to meet your needs.




## PATIENT INFORMATION

ARE YOU CURRENTLY UNDER THE CARE OF A HOME HEALTH AGENCY? YES / NO

Date of Birth:_______________________

Last Name:____________________________First Name:________________________Middle_________

Preferred Name if different from above:______________Social Security Number______ -_____ -_______

Marital Status: Single / Married / Widowed/ Other Male / Female

Address:______________________________________________________________________________

City:__________________________________State:________________________Zip code:__________

Home Phone:_______________________________Work Phone:________________________________

Cell Phone:______________________________ Email:______________________________________

If you would like to have an APPOINTMENT REMINDER, please fill out section below:

Circle one: CELL PHONE or EMAIL If Cell phone, *WE WILL NEED TO KNOW YOUR PHONE CARRIER IN ORDER TO SEND YOU A TEXT?* ____________________

Employment status: Full Time Employed / Part-time Employed / Not Employed / Self Employed /

Retired / Full Time Student / Part Time Student

## EMPLOYMENT INFORMATION:

Company:______________________________________________________________________________

Address:______________________________________________________________________________

City:__________________________________________State:________________________Zip code:_______

Phone Number:______________________________Extension:__________________________________

Department:____________________________________Job Title:______________________________

## EMERGENCY CONTACT INFORMATION:

Last Name:________________________________ First Name:____________________________

Relationship:______________________________ Phone Number:_________________________

## CHIEF COMPLAINT:

What are we treating you for?_____________________________________________________

What is the Onset Date (your initial symptom or pain) for this illness/injury?____________________

Have you had surgery for this?_______________When?_________

Have you had prior therapy for this?___________When?__________

Was this an accident related injury?___________If yes, when was the accident?_________________

Is this a work related accident?_______

Are you currently being seen by a Home Health Agency?_______

Have you been on home health within the past 60 days?________

If yes, which home health agency?_____________ What services do you receive? Nurse or Caregiver

Do you have a pacemaker or defibrillator? Yes No Are you pregnant? Yes No

*Referring* Physician:_______________________________________________________________

Address:_________________________________________________________________________

City:_________________________________State:_________________________Zip Code:_______

Phone Number:____________________________________________________________________

*Primary* Physician:__________________________________________________________________

Address:_________________________________________________________________________

City:_________________________________State:_________________________Zip Code:_______

Phone Number:____________________________________________________________________

***YOU ONLY HAVE TO FILL OUT INSURANCE INFORMATION IF THE INSURANCE IS NOT IN YOUR NAME!!!!!***

**INSURANCE INFORMATION:**

**Primary Insurance Company:**________________________________________

**Policy/ Member Id:**____________________**Group #:**____________________

**Relationship to Subscriber:**________________________________________

***If not self,*** **Subscriber Last Name:**__________________**First Name:**__________________

**M / F MARITAL STATUS:**________________**EMPLOYER:**____________________

**Subscriber Date of Birth:**__________________**Social Security #:**_______ - _______ - _______

**Address:**________________________________________

**City:**____________________**State:**______________**Zip Code:**__________

**Phone Number:**________________________________________

**SECONDARY INSURANCE COMPANY:**________________________________________

**Policy/ Member Id:**____________________**Group #:**____________________

**Relationship to Subscriber:**________________________________________

***If not self,*** **Subscriber Last Name:**__________________**First Name:**__________________

**M / F MARITAL STATUS:**________________**EMPLOYER:**____________________

**Subscriber Date of Birth:**__________________**Social Security #:**_______ - _______ - _______

**Address:**________________________________________

**City:**____________________**State:**______________**Zip Code:**__________

**Phone Number:**________________________________________

## LIST OF MEDICATIONS PATIENT CURRENTLY TAKES

__________________________ DOSAGE __________________

__________________________ DOSAGE __________________

__________________________ DOSAGE __________________

__________________________ DOSAGE __________________

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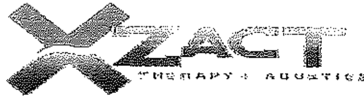


CONSENT TO TREATMENT

I am a patient/guardian of a patient at **Xzact Therapy & Aquatics**. My signature certifies that I have been informed of my rights and duties as a patient and that I have had opportunity to ask any questions I may have about those topics.

I understand that all information regarding diagnosis and treatment is confidential and will not be released to any entity or individual without my written consent unless required by law. I understand that some issues, such as child abuse or danger to the life or safety of a third party, may require **Xzact Therapy & Aquatics** to release information about my diagnosis and treatment. I have been provided with written information about my medical records, HIPAA law protections and the care to be provided by **Xzact Therapy & Aquatics** and have had opportunity to review those documents.

I have been informed that certain information regarding treatment and test results will not be given over the phone and that I must make an appointment with my provider to receive such information.

I have been told that certain services, including some laboratory tests, may not be paid for by my insurer and that I will be asked to sign an Advance Beneficiary Notice with regard to those services.

I have given my consent to **Xzact Therapy & Aquatics** its agents and employees to provide me with the treatment contained in my medical chart and records. I understand that I am responsible for paying for this treatment if my insurer does not cover that treatment.

I hereby designate the following individuals as authorized to access my medical records or to receive information from my provider:

I understand that email may not be a secure medium for transmittal of information. I authorize my provider to release test results or information to me via the following, where applicable:

___ phone number in my records ______cell phone _____email ______USPS

ASSIGNMENT OF BENEFIT:

I hereby assign all necessary medical/ physical therapy benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers, including Medicare, Medicaid, MCOs, private insurance and any other health or medical benefit plan to issue all payment directly to **Xzact Therapy & Aquatics** for medical services rendered to me or my dependents. Overage payments are to be credited to me in accordance with law. I understand that I am responsible for any amount not covered by insurance.

______________________________________________________________

Patient Signature Date

______________________________________________________________

Personal Representative Signature (if applicable) Relationship to Patient

I also have read and understand that the Cancellation and No Show policy on the initial page of this packet is in effect and I agree to comply with such.

______________________________________________________________

Patient or Responsible Party Signature Date