Blue Lagune Therapy, Inc

Comprehensive Aquatic & Physical Therapy

Welcome to Blue Lagune Therapy, Inc.

Blue Lagune Therapy would like to thank you for entrusting your Physical Therapy needs in our care. There are many choices of therapy facilities to choose from, and because you chose Blue Lagune Therapy we commit to providing you with the highest level of quality care to assist you in a speedy recovery.

As part of your orientation, the following information will help guide you through your course of treatment. Please take a moment to review the following information so that you will know what you can expect from us. We kindly ask that you bring your own personal towel, and wear comfortable attire during your aquatic and/or land therapy session to allow your therapist access to the area being treated.

Your first visit will consist of a complete Physical Therapy evaluation performed by a licensed Physical Therapist. During the evaluation, your physical therapist will review your physical history, current condition, and perform a complete physical examination. The physical examination will consist of specialized tests designed to assess your body mechanics as well as your strengths and weakness. This enables our team to develop an individualized program specifically designed to treat your diagnosis and particular functional limitations. During this time, you will have the opportunity to discuss your goals and plan of care with your physical therapist. Our therapy staff is always readily available to discuss any issues regarding your condition throughout your course of treatment. Your treatment at our facility will be as positive and effective as possible. Our goal is to alleviate your pain and return you to your maximum level of function.

When your plan of care begins, please be advised of the following:

1. Physical therapy is very effective in treating many conditions and restoring normal function. Your therapist will develop a plan of care that will help you achieve your goals. Your responsibility is to work with your therapist and let them know how you are responding to treatment. During your first few treatments, you can occasionally expect normal soreness; however, your soreness should subside after a few days. If you experience increased pain or discomfort, it is important for you to relay this information to your therapist so that they may adjust your treatment or exercise program accordingly.

2. Every treatment visit counts towards your road to recovery! It is a very important part of your plan of care. Therapy requires your commitment, active participation, and dedication. Please be compliant to your scheduled appointments. Cancelled/no show appointments should be rescheduled for another time in the same day or during that week. We cannot adequately address your needs if you do not attend your therapy treatment on a regular basis. Maximum benefits are reached when you are consistently attending your therapy treatment. Progression is diminished when you attend sporadically. We kindly ask for you to make every effort to be on time to allow courtesy to other patient's treatment time.

3. A home exercise program (HEP) will be given to you following your first few treatments of therapy. It is essential that you are compliant with your HEP. We encourage you to communicate your progress with your therapist during each treatment, so that they will know if there is a need to adjust your treatment or update your HEP.

4. When you are closer to the end of your therapy referral/prescription, usually after 31 days from your initial evaluation, a re-evaluation will be performed by your physical therapist. Re-evaluation is performed to give you an update of your progress and to determine If therapy should be continued or not. We will inform your doctor of your progress. Your physician will review the re-evaluation to determine if continued therapy is medically necessary. We will obtain a new referral for the continuation of your therapy treatment if your physician recommends additional therapy.

We understand your time is valuable and attending your therapy session is time consuming and expensive; however, it is the least expensive and non-invasive form of medical treatments. In an effort to restore you to function quickly and effectively, it requires attending therapy on a regular basis. As recommended and advised by your doctor, aquatic and/or physical therapy is the best course of action to assist you in regaining yourself to your maximum potential.

We value each session with you! Our physical therapy team will work diligently to help guide you through the exercises, strategies, and techniques to assist you in achieving your goals as outline in your plan of care.

Once again, we thank you for selecting Blue Lagune Therapy, Inc. to provide your therapy needs!

Best Wishes,

Blue Lagune Therapy, Inc.
1115 Avenue D
Katy, TX 77493

Blue Lagune Therapy, Inc

Comprehensive Aquatic & Physical Therapy

PATIENT INFORMATION

Patient Name:_______________________________ Sex: M / F Marital Status: M / S / W / D

Date of Birth:__________-________-_________ Social Security Number ------------------------- __________

Driver's License #:__________________________ State:__________Email: ________________________

Mailing Address:____Home #: _______________________

City:____________________State:_____________Zip:_________Cell Phone #:____________________

Patient Employer:_______________________________________Work #: ________________________

Occupation:____________________Spouse Name:______________________Spouse DOB:_________

Emergency Contact:_____________________________________Phone #:______________________

BILLING INFORMATION

Primary Insurance Co.:____________________________Phone: (_____)________-__________________

Address:_________________________________City:________________State:________Zip:____________

Primary Insured's Name:_________________________SS#______/____/______DOB_____/____/______Sex: M F

Insured ID#____________________Group#____________Relationship to the Patient __Self __Spouse____Child___Other

Employer:____Phone: (_____)________-_______________

Secondary Insurance Co.:____________________________Phone: (_____)________-________________

Address:_________________________________City:________________State:________Zip:____________

Secondary Insured's Name:_________________________SS#______/____/______DOB_____/____/______Sex: M F

Insured ID#____________________Group#________________Relationship to the Patient __Self __Spouse____Child___Other

Employer:____Phone: (_____)________-_______________

Tertiary Insurance Co.:____________________________Phone: (_____)________-__________________

Address:_________________________________City:________________State:________Zip:____________

Tertiary Insured's Name:_________________________SS#______/____/______DOB_____/____/______Sex: M F

Insured ID#____________________Group#________________Relationship to the Patient __Self __Spouse____Child___Other

Employer:____Phone: (_____)________-_______________

Have you had any chiropractic, physical, occupational/ speech therapy, or home health in the last 12 months? Yes / No

If yes, what treatment & when? ____

Patient/Guardian Signature:____**Date**:___________________

Motor Vehicle Accident

Is your injury due to a motor vehicle accident? Y / N If yes, when was the accident? ____________________

Auto Insurance Carrier Name________________________Policy/Claim #:__________________________

Adjuster's Name:________________Adjuster Phone:_______________Address:_____________________

Work Related Accident (Workers' Compensation)

Is your injury due to a work related? Y / N If yes, when was the accident? _____________________________

Claim #____

Workers' Compensation Insurance Carrier:______________________Phone:_____________Fax:___________

Employer Name_______________________________________Are you still employed here? Y / N

Employer Address:____City:_____________State:_____Zip:________

Adjuster's Name:_____________________________Phone:_______________Fax:______________________

Nurse Case Manager:_________________________Phone:________________Fax:_____________________

Describe your injury:____

____

____

____

____

____

____

____

____

____

Patient/Guardian Signature:____**Date**:_____________________

Blue Lagune Therapy Inc Patient History

Name ______________________________ Age: Ht: Wt: Date: ________________

Occupation: __________________________ Are you currently on work restriction? ________________

Are you currently receiving any Home Health Services? ☐ Yes ☐ No

Have you received any aquatic therapy, physical therapy, ☐ Yes ☐ No
speech therapy, and/or chiropractic services?

Was this injury work related? ☐ Yes ☐ No

If yes, is this being filed under ☐ Workers Comp or ☐ Employer

Please list your diagnosis or involved area: ____

List the date of injury or approximate date of onset of your condition: ________________________

Have you had surgery due to your condition? ☐ Yes ☐ No

If yes, please list the date of surgery & type of surgery & description:

1)______________________________ 3)______________________________

2)______________________________ 4)______________________________

Falls: In the past year, have you fallen 2 or more times: ☐ Yes ☐ No

Or in the past year, have you fallen 1 time and sustain an injury : ☐ Yes ☐ No

Do you have any allergies? Ie. Chlorine, latex etc….If yes, please lists them:

1)______________________________ 4)______________________________

2)______________________________ 5)______________________________

3)______________________________ 6) ______________________________

Are you diabetic? ☐ Yes ☐ No

If yes, are you taking oral medication or injections? ☐ oral ☐ injection

Have you abused alcohol or any illegal substances in the past 2 years? ☐ Yes ☐ No

Do you have any implants such as a pacemaker, pins, plates, screws, prosthetic joint, etc? ☐ Yes ☐No

Please list any other information that may be a factor in your treatment (ie. Pregnancy, claustrophobia, fear of water, aversion to hot/cold etc.

1)______________________________ 4)______________________________

2)______________________________ 5)______________________________

3)______________________________ 6) ______________________________

Are you taking any medications, vitamins, or supplements: ☐ Yes ☐ No

If yes, please complete the attached medication list form or provide a comprehensive list of all prescriptions medications, over the counter medications, vitamins & supplements, including name of the medication, frequency, and route of administration.

Blue Lagune Therapy, Inc Patient History

MEDICATION RECORD

(Including all prescription medication, over the counter medication, vitamins, supplements, etc…)

Patient:____DOB:________________Date:________________

#	Medication Name	Dosage	Frequency	Route of Admin (oral, injection, infusion, etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

(If you need additional room, please continue on the back of this form).

Blue Lagune Therapy, Inc Patient History

PLEASE TELL US ABOUT YOUR CURRENT SYMPTOMS

1. How did your symptoms start? ____________________

2. Have you been hospitalized for this problem? ☐Yes ☐No When? ________ How long? ________

3. What other treatment have you had for these symptoms? ____________________

4. My symptoms currently: ☐Come and go ☐Are constant ☐Are constant, but changes with activity

   ☐Getting Better ☐Getting Worst ☐Staying about the same

5. What tests have you had for these symptoms (MRI, X-rays)? ____________________

6. Does your symptoms changed by? ☐Sitting ☐Standing ☐Walking ☐Lying Other: ________

7. How are you able to sleep at night due to your current symptoms?

   ☐ I have no problem sleeping ☐ I have difficulty falling asleep

   ☐ I am awaken by pain ☐ I sleep only if I am medicated

8. How much of your daily activity are you able to do on a scale of 0 to 100%? ________

9. Where is most of your pain located (please circle)?

   Back Neck Shoulder Elbow Hand Hip Knee Ankle Foot

10. Pain Rating(please rate your pain on a numeric scale from 0 to 10, with 0=no pain, 10=Emergent pain)
Current Pain :________Least Pain(over last 2 weeks)______________Worst Pain (over last 2 weeks)__________

Blue Lagune Therapy, Inc

Comprehensive Aquatic & Physical Therapy

1115 Avenue D,
Katy, TX 77493-2465

The following list are precautions and contraindications towards participating in aquatic therapy. We are asking for your help to maintain a **healthy environment** for other patients and staff members. If you have experienced any of the following conditions recently or if they arise during the lifetime of your sessions in this facility, please notify a staff member.

Please initial each line If you are/have any of the following:

_____Sensitivity to disinfecting chemicals

_____Sensitivity to heat/ humidity (e.g Multiple Sclerosis)

_____Rashes, skin conditions with flaking or open areas (psoriasis, poison ivy/oak etc.)

_____Orthostatic hypotension

_____Open wounds with bio-occlusive dressing

_____Communicable diseases (cold flu, Hepatitis)

Please Initial each line indicating that you understand if/ when you should have the following you will notify our office:

_____Bowel incontinence with diarrhea or firm stool, and no stool program

_____Bouts of diarrhea caused from possible viral/bacterial infection. (aquatic therapies should be moved to land for 1-2 weeks following last loose bowel movement

_____Recent vomiting or nausea, regardless of the cause

_____Open wounds or bleeding without bio-occlusive dressing (including menstruation without internal protection)

_____Presence of DVT (deep vein thrombosis) without anticoagulation therapy or filter

Please initial each line indicating you have read and will follow the below pool rules:

_____Entering/exiting the pool should be done via steps/stairs at all times.

_____No climbing over adjoining wall between pool and spa or over edge to pool/spa walls to enter or exit water.

_____No open swimming unless directed by facility staff for therapeutic purposes

_____No camera/photos/ facetiming in treatment area(land or pool)

Patient Signature:______________________________________Date: _______________________________

Date:_________________

Blue Lagune Screening Tool

Patient's Name: ____

Please let us know if you have had any of the following:

	YES	NO
Fever of 100.4°F within the last 14 days	☐	☐
Cough/Shortness of Breath	☐	☐
Pneumonia/flu - recent	☐	☐
Have you had contact with anyone who has lab confirmed Novel Coronavirus within 14 days of symptom onset?	☐	☐

Patient signature:____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby instruct and direct the above insurance company to pay by check made out and mailed to:

1115 Avenue D Katy, TX 77493. For the medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney on my behalf. **I understand that the verification of benefit is only an explanation of coverage from my insurance company and it is not a guarantee of coverage**. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of these services. **I understand that I am responsible for deductibles, co-insurance, co-pays and any non-covered services.** ***I understand that I am also responsible for payments in which my insurance carrier may inadvertently send to the primary policy holder or myself instead of to the provider and will forward payment to Blue Lagune Therapy to be applied to my account.***

CANCELLATION / NO SHOW POLICY

Please be advised that we understand that sometimes situations arise, and you may be unable to keep your appointment. We ask that you give 24-48 hour notice if your appointment must be cancelled or rescheduled. This allows other patients who may be on the wait list the opportunity to come in to an earlier scheduled appointment. **There is a $25 charge for missed appointments that are not properly cancelled/no call/no show.** This will be paid at your next visit. After the second consecutive no show, all future appointments scheduled will be cancelled until the patient is able to commit to their schedule. If you are covered by Worker's Compensation, we must notify your adjuster/case manager of missed appointments without cancellation.

RELEASE OF LIABILITY

I understand that the aquatic therapy and physical therapy offered at Blue Lagune Therapy, Inc requires physical activity, and I hereby acknowledge that my physical condition permits me to participate. I acknowledge that I have been advised that at any time I am having difficulty of any kind to notify facility personnel and carefully stop all activity. I acknowledge and accept the responsibility and all of the risks that occurs at/on the premises. Blue Lagune Therapy, Inc is not responsible for loss of or damage to any personal effects (money, jewelry, keys, etc) which I bring to the facility. I agree to abide by the facility rules and guidelines. I agree to conduct myself in a safe manner at all times. I also release and discharge on behalf of myself, my heirs, assigns and successors in interest, all officers, directors, owners, agents, and employees, and other representatives of Blue Lagune Therapy, Inc and it's insurers, from any and all claims, damages, demands, losses, and liabilities arising out of or in any way related to participation with Blue Lagune Therapy, Inc's aquatic and physical therapy programs, exercise programs, activities, procedures, swim or any other activities or results attained there from. I understand that this is an aquatic facility and acknowledge and understand the risk and wet floor are present; therefore I also release all liabilities and hold Blue Lagune Therapy Inc /DMXQ LLC, Inc harmless of incidents/accidents that occur on the premises at Blue Lagune Therapy, Inc. The patient is informed that Blue Lagune Therapy Inc. is under continuous 24 hours surveillance.

NOTIFICATION OF CHANGES IN ADDRESS OR INSURANCE COVERAGE

The patient and/or guarantor is responsible for informing Blue Lagune Therapy, Inc. of any changes in their insurance coverage or their personal contact information. If failure to report these changes prevents Blue Lagune Therapy, Inc from obtaining reimbursement from the patient and/or guarantor's insurance company for services rendered, the patient and/or guarantor will be liable for all unpaid charges that would have been paid by their insurance company.

Patient/Guardian Signature:____**Date**:____________________

PRIVACY NOTICE

This notice describes how information about you may be used and disclosed and how you can get access to this information.

Please Review Carefully

WHO WILL HAVE ACCESS TO YOUR INFORMATION

Blue Lagune Therapy, Inc (“we”, “us”, “our practice”) provide aquatic and land physical therapy and other services necessary to provide optimal rehabilitation to you, our patient/client. Because many individuals within the facility need to access your clinical and billing records we have declared all of our employees as eligible to manage all of your health information. Specifically, this means all clinical staff (employed or contracted), all interning students, volunteers and all off personnel (employed or contracted). Typically, your clinical information and billing information would be accessed for treatment and related billing purposes only. However clinical and billing audits are required by professional and regulatory standards. Your records could, therefore, be randomly selected as part of these compliance and quality assurance purposes. A business associate is a person/entity that provides services or activities to a health care provider or covered entity. Business associates who have access to your information will be strictly limited to those who provide billing and collections, document archiving, copying and disposal services. All of these individuals are under contract and have been educated regarding patient rights and privacy regulations.

OUR PLEDGE REGARDING MEDICAL INFORMATION

Blue Lagune Therapy, Inc (“ we”, “ us”, “ our practice”) understand that medical information about you and your health is personal. We are strongly committed to protecting your medical information. We simply record in detail the care and services that you receive at our facility, by doing so it also assists us in meeting certain legal requirements. This notice applies to all of the records that are generated by us, whether made by our employees or our contracted personnel. Your personal physician may have different notices regarding his/her use and disclosure of your medical information created in his/her office. It is important that you are familiar with and understand how each health care provider handles your health information. This notice will tell you about the ways we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

WE ARE REQUIRED BY LAW TO

- Assure that all health information that identifies you is kept private
- Provide you with a “Notice of Privacy Practices” relating to our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Privacy Practices Notice provided to you

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe ways that we may use and disclose health information. All of the ways we are permitted to use and disclose information will fall within one of the following categories.

For Treatment:

We may use health information about you to provide you with rehabilitation or related services. We may disclose health information about you to other therapists, doctors, nurses, technicians, clinical students or other clinical or support personnel needed to assist in optimal care delivery. This might also include disclosing or using your health information to educate and train a designated family member to assist with home rehabilitation or activities support.

For Payment:

We may use and disclose health information about you so that treatment and services you receive from our staff may be billed to and payment may be collected from your insurance company, third party payor or you. We may need to disclose health information to your health plan/payor about treatment or intervention you are going to have in order to obtain prior approval or to determine whether there is specific coverage for the services to be delivered to you.

Consents, Authorization and Access:

All providers are required to adhere to the privacy regulations stipulated in the Health Insurance Portability and Accessibility Act (HIPAA) effective in April 2001. The primary focus of the privacy section of the HIPAA is to require that heath care providers manage all health care information in a confidential and “need to know” basis. This includes paper documents, electronic data and telephonic communications. HIPAA requires that all patients/clients have full access to their health information and that they are given the right to review copy and amend it, as specifically requested. While consents for provider services are unnecessary, authorizations for use of health information outside of treatment, treatment-related operations and/ or payment are required a signed authorization form giving permission to utilize protected health information. Other providers and provider related services noted above must be obtained prior to disclosing or using private health information. The Act clearly states that the health care provider may not restrict access to services or in any way penalize a patient/ client in the event of authorization declination or authorization revocation. (Please sign and date the line below indicating that you have read and understood this form).

____

Patient’s Signature/Date

Payment Policy **BLUE LAGUNE THERAPY** **DMXQ, LLC**

Thank you for choosing us as your Provider. We are committed to providing you with quality and affordable health care. Our office is committed to the success of your treatment and care and realize that communication is vital to the patient's well-being. A mutual understanding is part of our relationship and we need your assistance and understanding of our financial agreement. It is important for you to understand the terms of your health insurance policy. Your policy is a contract between you and your insurance carrier.

1. **Proof of insurance**. Valid health insurance information must be provided to us to ensure appropriate reimbursement for your care. All patients must complete our patient information form before getting the treatment. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance does not pay 100%, you will be responsible for any deductible, co-payment, coinsurance, and any non-covered services

2. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance does not pay 100%, you will be responsible for any deductible, co-payment, coinsurance, and any non-covered services

3. **Insurance**. Valid health insurance information must be provided to us to verify if your policy has "in-network" or "out-of-network" benefits. Prior to scheduling, you will be informed with an estimate of cost. If you are not insured by a plan, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. We assist you in verifying your benefits prior to your initial visit. We provide an estimated amount that you will be responsible for each visit. Knowing your insurance benefits is ultimately your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

4. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. We will provide an estimate of cost base on your benefits, but is subject to change dependent on final claims process from your insurance.

5. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

6. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. <u>Your insurance benefit is a contract between you and your insurance company; we are not party to that contract</u>.

7. **Patient Statements.** Once all claims are process by your insurance, you may receive a statement base on claims process. In this event, statements will be sent to you in effort to attempt to collect the outstanding balance. Patients receive at least four (4) balance-due statements and a series of phone call attempts, in effort to collect on balance is paid. Payment Methods: We accept cash, check, MasterCard, Visa and Discover.

8. **Non-payment**. If your account is over 120 days past due, Payment arrangements have been made and agreed upon. If balance cannot be paid, you can apply for financial hardship or request for a prompt pay discount.

Our practice is committed to providing the best care to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines: I will cooperate with the billing department to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial agreement may be amended at any time without prior notification to me, the patient.

___________________________________ ____

Signature of patient or responsible party Date

_______________________________________ (PRINT NAME)