First Colony Aquatic and Rehabilitation Center LP
20403 University Blvd
Suite 100
Sugar Land, TX 77478
281-325-0188 Fax: 281-325-0189

FirstColony Aquatic and Rehabilitation Center

Please complete all fields **Today's Date:**_____

Social Security #	Date of Birth	How did you hear about us?	
Last name	Suffix	First name	Middle Initial
Address	Referring Physician		
City	State	Zip	
Home phone	Work phone	Cell Phone	
Sex: ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Other	Email Address:	

Other Information

List other physicians to whom you want us to send medical updates:

Insured Party/Responsible Party (Leave blank if same as patient)

Social Security #		Date of Birth	
Last name	Suffix	First name	MI
Address			
City		State	Zip
Home phone		Work phone	

Patient's Employer Information **Insured's Employer information (leave blank if same as patient)**

Employer name			Employer name		
Employer address			Employer address		
City	State	Zip	City	State	Zip

Emergency Contact Information

Last name	First name	MI
Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Friend ☐ Other		
Home phone:	Work phone:	

Patient Certification and Signature

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____ Date:_____

First Colony Aquatic and Rehabilitation Center LP
20403 University Blvd
Suite 100
Sugar Land, TX 77478
281-325-0188 Fax: 281-325-0189

FirstColony Aquatic and Rehabilitation Center

Patient History

Name	Age
Occupation	Physician

Do you now or have you ever had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes	☐	☐	Open Wounds	☐	☐	Thyroid Problems	☐	☐
Arthritis	☐	☐	Current Infection(s)	☐	☐	CVA/Stroke	☐	☐
High Blood Pressure	☐	☐	Hypersensitivity to Heat/Cold	☐	☐	Previous Fractures	☐	☐
Heart Disease	☐	☐	Allergies	☐	☐	Osteoporosis	☐	☐
Pacemaker or Surgical Implant	☐	☐	Presently Pregnant	☐	☐	Anxiety	☐	☐
Vascular Disease	☐	☐	Seizures	☐	☐	Substance Abuse	☐	☐
Headaches	☐	☐	Metal in Body	☐	☐	Previous Surgeries	☐	☐
Kidney Problems	☐	☐	Cancer/Tumor	☐	☐	Other	☐	☐

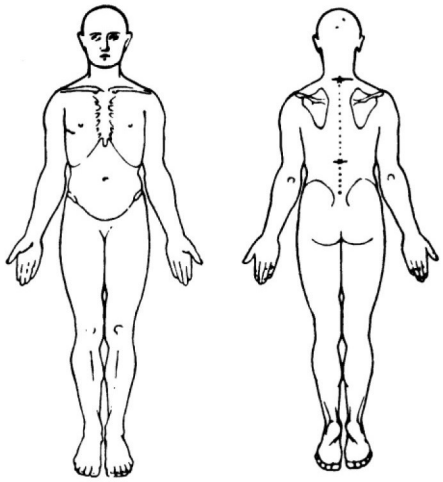
Please tell us more about your accident and/or symptoms:

1. When did it start? Date?_____
2. What were you doing? _____
3. Where is most of the pain located? ☐back, ☐neck, ☐shoulder, ☐elbow, ☐wrist, ☐hand, ☐hip, ☐knee, ☐ankle, ☐foot
4. Did you have surgery? ☐yes, ☐no If so, what was the type and date of surgery?

   _____
5. Are you taking any medication? ☐yes, ☐no. If so, what type of medication?

   _____
6. How much of your daily activities are you able to do now on a scale from 0 to 100%? _____
7. Female patients only – are you now or could you be pregnant? ☐yes, ☐no
8. Indicate your level of pain: 0 = best, 10 = worst _____
9. Within the last year, have you fallen one time with injury? ☐yes, ☐no
10. Within the last year, have you fallen two times with injury? ☐yes, ☐no
11. Height _____
12. Weight _____
13. BMI (Office Use Only) _____

Color-in where you have symptoms:



First Colony Aquatic and Rehabilitation Center LP
20403 University Blvd
Suite 100
Sugar Land, TX 77478
281-325-0188 Fax: 281-325-0189

FirstColony Aquatic and Rehabilitation Center

Assignment of Benefits:	
I authorize payment directly to First Colony Aquatic & Rehab Center and its subsidiaries and/or affiliates for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.	
Patient or Guardian Signature: **X**	Date:
Financial Guarantee:	
I agree to pay First Colony Aquatic & Rehab Center and its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for the speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Benefit Verification form is only an explanation of coverage obtained 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 services. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of First Colony Aquatic & Rehabilitation Center, and/or its affiliates or subsidiaries	
Patient or Guardian Signature: **X**	Date:
Consent of Treatment:	
I hereby give consent to be evaluated and treated for physical/occupational therapy at First Colony Aquatic & Rehab Center. I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment of the above named patient at First Colony Aquatic & Rehab Center.	
Patient or Guardian Signature: **X**	Date:
Appointment Policy:	
Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. We require advance notice of 24 hours of cancellation. Failure to show for an appointment or cancellation without sufficient notice may be subject to a $25.00 charge.	
Patient or Guardian Signature: **X**	Date:
Privacy Practice Acknowledgement:	
My signature below indicates that I have been given the Notice of Privacy Practices for First Colony Aquatic & Rehab Center. I recognize that outside of purpose for treatment for payment and certain healthcare operations I must give my written authorization to release any of my protected healthcare information.	
Patient or Guardian Signature: **X**	Date:

First Colony Aquatic and Rehab Center, LP.
Authorization for Release of Information

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or If required or Permitted by Law or Rules

Patient's Printed Name: _____
Last First MI

Date of Birth: ____/_____/_____ Social Security Number : _____-_____-_____

Address: _____
Street or PO Box City State Zip Code

Phone: (Day) _____ (Evening) _____ (Cell)_____

I hereby authorize First Colony Aquatic and Rehabilitation, LP. to release the information below to the individual (s) or entity identified by name:

Spouse:_____ Attorney:_____
Parent: _____ Employer:_____
Friend: _____ School: _____
Other:_____

_____

Information	Date of Services(all or limited to)	Exp. Date, If any
☐ All Records Related to My Care at First Colony Aquatic and Rehabilitation	_____	_____
☐ Evaluation/Examination	_____	_____
☐ Past Medical History	_____	_____
☐ Treatment Records	_____	_____
☐ Correspondence Re: Rehab Status	_____	_____
☐ Attendance	_____	_____
☐ Other: _____		

Initials

_____ I understand that this authorization will expire on ____/_____/_____ if not indicated above
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment or payment compromises
_____ I understand that the information use/disclosed as a result of authorization may be subject to redisclosure by the recipient and will no longer be protected by Federal privacy regulations
_____ I understand that if I am being asked to release information by FACILITY I have been told the purpose and to whom it is being release to : Indicate what you have been told: _____
_____
_____ I understand that I will receive a copy of this authorization after I sign it and before, if request it
_____ I understand that FACILITY _____ will ____ will not receive compensation for using or disclosing my health information

_____ or _____
Signature of Patient Date Signature of Parent or Authorized Representative Date
(Indicate the relationship)

You May Refuse this Authorization