

Community Integration Services

Harriet E. Ott, ATRIC, CTRS
704 228th Ave NE #745
Sammamish, WA 98074
425-830-7746 / harrietott@comcast.net

Please complete all the sections below.

You can mail this to the address below, or complete after setting up an appointment over the phone.

The Doctors order is optional, having the order will allow you to deduct the expenses from your medical Expenses report.

Registration for Private Aquatic Therapy Sessions

Referred by

Name (client)-----

Billing Address-----

City _____ Zip_____

Phone _____ cell phone _____

Date of Birth _____

Email address _____

Diagnosis-----

Cause: _____ date of onset _____

Medical History (surgeries, allergies, medication)

Physician----- Phone _____

Address _____ City _____ Zip_____

Insurance-----

Hospital of Preference-----

Leisure History (Previous swimming experiences, Group experiences,)

What are your goals for these aquatic therapy sessions?

Mobility (walks independently, balance issues, assistive devices, wheel chair, crutches, braces, gross motor skills)

ADL's: How much assistance is needed in areas of (toileting, dressing, fine motor skills)

Cognition (communication, speech impairment, ability to follow verbal directions,)

Medical Release/Release of Liability

I give my permission for Harriet E. Ott of Community Integration Services to review the medical charts and/or for you to give her medical information relating to the medical needs of:

I release Community Integration Services and _____ (facility name) from any possible injury that may arise as a result of participating in this program. I hereby assume all risk of liability for injury, damage and other consequence. I waive the right to bring suit against "Community Integration Service," holding them harmless from any and all claims.

Name (Please print)

Date of Birth

Signature

Date

Community Integration Services

Physicians Order form

Harriet E. Ott, CTRS
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_____ may participate in Community Integration Services
for Aquatic Therapy Activities

Precautions for _____ while participating in Aquatic
Therapy are:

Mobility _____

Range of Motion _____

Cognition _____

Other _____

Diagnosis

Physician Full Name _____

Address/City/Zip _____

Professional License Number _____

Phone number _____

PHYSICIAN SIGNATURE

Date

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This agreement is made between _____
and Harriet E. Ott, Director of Community Integration Services for aquatic therapy
sessions at _____

Goal:

- To learn adaptive tools and techniques to swim safely in the water.
- To increase strength, mobility, and function through aquatic therapy sessions

Services provided

- Support services to be successful in leisure time activities.
- To teach aquatic skills to be independent in a community facility, while meeting rehabilitation goals.

Terms

- Aquatic Therapist Fee: \$80.00/hour private (50 Minutes) / \$50.00 half hour session (25 minutes)
- Aquatic Specialist: \$75.00/hour private (50 minutes) / \$45.00 half hour session (25 minutes)
- Aquatic Aid/Instructor: \$60.00/hour private (50 Minutes) / \$38.00 half hour session (25 minutes)

- Billing** will be on the 1st of each month

Payment due within 15 days. 10% late payment charged on bills 30 days over due
I prefer to receive payments through the mail. Staff do not have a good place to receive checks at the pool.

- Admissions** fees to community facilities included
- Administration charge** of (one time only) \$50.00.

This fee covers the cost of all your paper work, this would include collaborating with your other therapists by phone or sharing progress reports, research resources and progress notes to physician, therapists, schools as needed.

Cancellation policy

- Full credits are given when 24-hour cancellation is provided.
- No Credit is given with less than 24 hours cancellation notice.

Client/Guardian

Harriet E. Ott, ATRIC, CTRS

date _____
date _____