25591 Coolidge Hwy.
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Phone (248) 331-9490 Ext. 1
Fax (248) 331-9254

26445 Gratiot Ave.
Roseville MI, 48066
Phone (248)-331-9490 Ext. 3
Fax (248)-444-6940

14501 Telegraph Rd.
Redford, MI 48239
Phone (313) 693-4188
Fax (248)-542-8990

PATIENT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____

HOME PHONE#: _____CELL PHONE#: _____DOB: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: S M D SEP (CIRCLE ONE)

EMPLOYER: _____OCCUPATION: _____WORK PHONE#: _____

ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

HEALTH INSURANCE INFORMATION

CARRIER: _____ INSURANCE CO. PHONE#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

POLICY#: _____GROUP#: _____

PATIENTRELATIONSHIPTOTHEINSURED: SELF SPOUSE CHILD OTHER (CIRCLEONE) **IF YOU ARE COVERED UNDER ANOTHER PERSON'S INSURANCE, PLEASE COMPLETE BELOW**

NAME OF INSURED: _____ INSURED PHONE#: _____ SEX: _____

DOB: _____ INSURED'S EMPLOYER: _____

AUTO ACCIDENT INSURANCE

CARRIER: _____ CLAIM#: _____ACCIDENT DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MED. CLAIM ADJUSTER: _____PHONE#: _____

ATTORNEY NAME: _____PHONE#: _____

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PATIENT MEDICAL/HEALTH HISTORY

NAME: _____TODAYS DATE: _____

CONDITIONS: **PLEASE CIRCLE AND EXPLAIN ALL THAT APPLY:**

NECK PAIN: **YES** **NO** _____

LOW BACK PAIN: **YES** **NO** _____

SHOULDER, ARM, HAND PAIN: **YES** **NO** _____

BROKEN BONES: **YES** **NO** _____

METAL IMPLANTS: **YES** **NO** _____

CIRCULATION PROBLEMS: **YES** **NO** _____

LEG PROBLEMS: **YES** **NO** _____

HEADACHE: **YES** **NO** _____

DIZZINESS: **YES** **NO** _____

ARE YOU PREGNANT: **YES** **NO** _____

MAJOR SURGERIES: **YES** **NO** _____

OTHER: (PLEASE DESCRIBE) _____

DO YOU SUFFER FROM:

1.) **DIABETES** **YES** **NO**

2.) **HEART TROUBLE** **YES** **NO**

3.) **CANCER** **YES** **NO**

4.) **ALLERGIES** **YES** **NO**

5.) **HIGH BLOOD PRESSURE** **YES** **NO**

6.) **SEIZURES** **YES** **NO**

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PHYSICAL THERAPY TREATMENT/REIMBURSEMENT LIEN

I irrevocably assign all of my rights and benefits under my auto insurance contract to, Aquatic Solutions Physical Therapy, LLC for reimbursement of services rendered directly to me. I authorize you to file insurance claims on my behalf for services rendered to me as a result of this accident which specifically includes filing arbitration/litigation in the facilities name on my behalf against the PIP carrier/Healthcare carrier. I irrevocably authorize you to retain an attorney of your choice on your behalf for collection of bills relating to my accident and treatment. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize/consent you to act on my behalf for the entire duration of my treatment with this facility.

In the event the insurance carrier responsible for medical payment in the matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited power of attorney and appoint the facilities collection attorney as my agent to collect payment for any/all medical services directly against the carrier in this case including filing an arbitration, demand, or lawsuit. I specifically authorize said attorney to file directly against my insurance carrier in my name or the facilities name as a medical provider rendering services to me.

I fully understand that while Aquatic Solutions Physical Therapy, LLC will pursue by any/all means necessary direct payment from my auto insurance carrier for the reasonable and necessary medical treatment rendered to me by Aquatic Solutions Physical Therapy, LLC that ultimately I, and I alone, am solely and directly financially responsible for payment of the medical services provided to me by Aquatic Solutions Physical Therapy, LLC. This lien serves as an express recognition of my responsibility to pay in full as to any/all treatment rendered and to ensure that any unpaid balance is resolved either personally or from proceeds received from any settlement or judgement, related to my motor vehicle accident.

I authorize you and or your assigned to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient Signature: _____Date: _____

Patient Name: _____ **Date of Injury: _____**

Guardian Signature: _____ Date: _____

The undersigned, being the patient's attorney of record, does hereby agree to observe all the above terms and agrees to withhold any and all funds to adequately protect the facilities outstanding balances from any settlement, judgment or verdict as may be necessary.

Attorney Signature: _____ Date: _____

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HIPAA AUTHORIZATION FOR MEDICAL RECORDS

Consistent with my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby authorize physicians, hospitals, clinics and any other medical institutions or medical providers to disclose my medical information to Auto Club Insurance Association, Auto Club Group Insurance Company, Member Select Insurance Company and/or Chicago Motor Club Insurance Company, all of which are referred to herein as "Auto Club Insurance."

Auto Club Insurance may request my entire medical record, for all dates of service, including the history, x-ray, physical findings, diagnosis, prognosis, condition, treatment, and dates and costs of treatment. Medical providers are required to provide this information under the Michigan motor vehicle no-fault insurance law, P.A. 294 of the Public Acts of 1972. Auto Club Insurance may request this information to determine if I am entitled to benefits under the no-fault law, including medical expenses, wage loss, replacement services and survivors' loss.

I understand that I can revoke this authorization, with respect to a specific medical provider, by writing to the person identified in the provider's Notice of Privacy Practices, subject to the expectation set forth in the Providers Notice.

This authorization will remain valid until I am no longer eligible for no-fault benefits from the Auto Club Insurance.

I understand that medical providers will not condition my treatment on whether I provide this authorization for disclosure.

I understand that once information is disclosed it may be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

Name of Patient or Personal Representative	**Date**
Signature of Patient or Personal Representative	**Relationship to Patient/Description of Personal Representative Authority**

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HIPAA CONSENT

I _____, give Aquatic Solutions Physical Therapy, LLC to use and disclose my health information for the purpose of diagnosing and providing treatment to me, and obtaining payment for my health care.

I understand that I have the right to inform Aquatic Solutions Physical Therapy, LLC about how I would like my healthcare information to be used or disclosed during my treatment.
I have the right to discontinue my therapeutic service at Aquatic Solutions Physical Therapy at any time.

I understand that Aquatic Solutions Physical Therapy, LLC will use my health information, including my demographic information. I also understand that Aquatic Solutions Physical Therapy, LLC will not share my information with individuals other than my physician, insurance company, or my insurance representative without my signed consent.

By providing my wireless phone number to Aquatic Solutions Physical Therapy, LLC, I agree and acknowledge that Aquatic Solutions Physical Therapy, LLC may send text messages to my wireless phone number for any purpose, including marketing purposes. I agree that these text messages may be regarding the products and/or services that I have previously purchased and products and/or services that Aquatic Solutions Physical Therapy, LLC may market to me. I acknowledge that this consent may be removed at my request but that until such consent is revoked, I may receive text messages from Aquatic Solutions Physical Therapy, LLC at my wireless number.

By signing this consent, I agree to allow Aquatic Solutions Physical Therapy, LLC to provide outpatient physical therapy services to me.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Name of Patient or Personal Representative **Date**

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Physical Therapy and Massage Therapy Consent Form

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, manual treatment, massage, exercises, and physical agents to aid the client in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Manual and Massage treatment includes placing hands on the client, with proper draping techniques as needed. Verbal consent will be taken prior to each manual/massage treatment session.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol.

Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with your treating physical therapist throughout your treatment regarding pain, symptoms, adverse reactions etc. Should you experience any adverse reactions following therapy, notify your treating physical therapy and seek medical attention immediately.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical/massage therapy and agree to fully cooperate, participate in all physical/massage therapy procedures, and comply with the established plan of care.

_____ _____

Name of Patient or Personal Representative **Date**

_____ _____

Signature of Patient or Personal Representative

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Appointment Cancellation Policy

In an attempt to be more consistent with scheduling, we have implemented the following policy regarding cancellations. This policy has been implemented in order to ensure fairness to all clients that require aquatic therapy, and those who are unable due to limited availability at this time.

Our policy is as follows:

- We require all clients to give our office **48 hours notice** in the event that he/she is unable to attend a therapy session and needs to cancel/reschedule.
- If you miss an appointment without contacting our office within the required time, you will be given a **verbal warning**.
- After the first warning, if you miss another appointment without contacting our office within the required time, you will be **taken off the water schedule,** and placed on land only.

If you have any questions regarding this policy, please let our office staff know, and we will clarify any questions/concerns you may have.

We thank you for your cooperation.

I have read and understand the Appointment Cancellation Policy and agree to the terms.

I, _____ (Print Name), have read and agree to the terms of Aquatic Solutions Physical Therapy's Appointment Cancellation Policy.

_____

Signature **Date**

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Patient Bill of Rights

To be treated with respect, consideration and dignity regardless of psychosocial, spiritual and/or cultural values

To feel secure of self and property

To be provided physical access to the facility for the physically and visually impaired

To obtain the name and function of any person providing services to you

To be provided with privacy and safety during care

To expect that all information gathered during treatments, disclosures, and records are treated confidentially, except when required by law, and to be given the opportunity to approve or refuse their release

To be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient to be a legally authorized person.

To be given opportunity to participate in decisions involving their health care, except when participation contraindicated for medical reasons

To receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment, except in emergencies. Such information for informed consent should include the specific procedure and/or treatment, significant medical risks involved, and the probable duration of incapacitation. Where significant alternatives for medical care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information and the consequences of not complying with therapy. The patient has the right to know the name of the person responsible for the procedures and/or treatment.

To refuse treatment and be informed of consequences of refusing treatment or not complying with therapy

To have complaints reviewed, and, when possible, resolved

To be informed as to:

- Expected conduct and responsibilities as a patient
- Services available from the facility
- Provisions for after-hours and emergency care
- Fees for services
- Payment policies
- Procedure for reporting health concerns to the appropriate authorities at: Michigan

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- Department Licensing and Regulatory Affairs — 800-882-6006
- Their reports of pain will be believed
- Information about pain and pain relief measures
- A concerned staff committed to pain prevention and management
- Health professionals who respond quickly reports of pain
- Effective pain management

Patient's Responsibilities

- A patient is responsible for providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health.
- A patient is responsible for reporting unexpected changes in his condition to his health care provider.
- A patient is responsible for reporting to his health care provider whether he comprehends a contemplated course of action and what is expected of him.
- A patient is responsible following the treatment plan recommended by his health care provider.
- A patient is responsible for keeping his appointments and, when he is unable to do so for any reason, for notifying the clinic.
- A patient is responsible for his actions if he refuses treatment or does not follow the
- health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his health care are fulfilled as promptly as possible.
- A patient is responsible for following clinic rules and regulations affecting patient care and conduct.

Patient Signature: _____ Date: _____

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Aquatic Therapy Pool Rules

1. Please shower off prior to entering the pool.
2. Please wear appropriate swimwear. (Shorts and T-shirts are welcome if they have been pre-washed to set dyes.)
3. Women: One-piece suite preferred. Absolutely no bikinis or thong suits
4. Men: No thong Trunks – boxer trunks preferred o T-shirt worn in water should be white, grey, or black
5. No street shoes are allowed in the pool (aquatic shoes may be used)
6. No lotions or perfume
7. Never enter the water unless a staff member is present to assist you.
8. Please perform only those activities / exercises you are instructed to perform.
9. Please bring change of clothes, sandals, etc. Lockers are available in the changing areas.
10. If you need assistance changing, please bring a caregiver that will be available to assist you.
11. Allow enough time for changing/showering when scheduling your appointments.
12. Please dry off completely in the pool area prior to proceeding to the changing areas
13. Please use the restroom before entering the pool
14. No food or beverages are allowed in the pool
15. Disruptive behavior will not be tolerated
16. Notify your therapist if you have an open wound or rash
17. Do not leave personal items in the restroom, unless it's in a locker
18. Arrive for appointments with enough time to change beforehand
19. If you experience dizziness, or any other illness, please exit pool immediately and inform your physical therapist

The Aquatic Therapy Pool rules have been designed to ensure a quality experience and optimal patient safety. Your cooperation is appreciated.

Thank You!

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ASSUMPTION OF RISK WITH AQUATIC THERAPY

Your Physical Therapist, after evaluating your condition, has concluded that you are an appropriate candidate for aquatic/pool therapy. Although you will be closely supervised by a licensed/certified health care provider who is CPR/First Aid certified at all times, there is always an increased risk for injury when entering any aquatic environment. In order to minimize this risk, please answer the following questions as honestly as possible.

1. Rate you fear of water?
    a. No Fear
    b. Somewhat Fearful
    c. Very Fearful
    d. Extremely Fearful
2. Are you able to swim?
    a. Yes
    b. No
3. Do you consider yourself a strong swimmer?
    a. Yes
    b. No
4. Can you put your head under water?
    a. Yes
    b. No
5. Are you able to float on the water without assistance?
    a. Yes
    b. No
6. Do you have any balance difficulties?
    a. Yes
    b. No

Please understand that there is always a risk of slipping and falling whenever entering or exiting the pool area. Exercise caution and follow all instructions and regulations regarding the use of the pool. If at any time you decide you do not wish to be treated in this particular setting, please inform your Physical Therapist and we will gladly substitute an appropriate alternative.

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CONTRAINDICATIONS & PRECAUTIONS FOR AQUATIC THERAPY

There are certain health conditions that may make aquatic therapy inappropriate for some individuals. For your safety, please mark all items that are, or have been relevant to you.

1. Water borne diseases (typhoid, cholera, or dysentery).
2. Current fever higher than 100 degrees Fahrenheit
3. Cardiac Failure
4. Gastrointestinal Disorders
5. Open Wounds
6. High or Low Blood Pressure
7. Kidney Diseases
8. Contagious Skin Rashes
9. Perforated Ear Drums
10. Incontinence
11. Psoriasis
12. Radiation Treatment (w/in 3 months)
13. Infectious Diseases
14. Other conditions which may affect using the pool

Please be advised that this pool is treated with Chlorine. If you have had a known reaction or believe you may be allergic to Chlorine please advise your therapist. My signature below indicates that I have read the rules for aquatic therapy and agree to abide by them.

_____

Name (Please print)

_____ _____

Signature Date

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PATIENT RESPONSIBILITY NOTICE

- **I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.**
- **Co-pays are due at the time of service.**
- **It is the responsibility of the patient to verify their health insurance benefits, although we also verify as a courtesy.**

Patient Signature **Date**

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Shower Facility Usage Liability Waiver

In order to use the shower facilities located at Aquatic Solutions Physical Therapy (Oak Park, Redford, Roseville, MI Locations, hereinafter referred to as “Shower Facilities”), I hereby certify as follows:

1. I understand that in utilizing the Shower Facilities, there is a possibility of accidental or other physical injury. I agree to assume the risk of such injury and not hold Aquatic Solutions Physical Therapy responsible for any and all injury or damage resulting from the use of the Shower Facilities.

2. I understand that there are no personnel, surveillance or security provided in the Shower Facilities to protect me from third parties or other risks i.e. slip/fall, and I enter and use the Shower Facilities at my own risk.

3. I understand that I have the ability to bring an individual to assist in the Shower Facilities, however one will not be provided by Aquatic Solutions Physical Therapy.

4. I acknowledge that I will abide by all rules and regulations governing the use of the Shower Facilities.

OR

☐ I decline to agree to terms 1-4, I understand that Aquatic Solutions Physical Therapy has the right to refuse usage of Shower Facilities and perform Water Therapy due to safety concerns if I decline to the above terms.

Full Name (Print): _____

Full Name (Signature) _____ Date: _____

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Thank you for choosing Aquatic Solutions Physical Therapy as your physical therapy clinic. We would like to know how you were referred to us or heard about us. Please fill in the survey below.

Your Name:_____

How did you hear about us, please circle the one that applies to you and write additional comments if needed.

1. Walk in/ Drive by: _____
2. Online: _____
3. Doctor Referral:_____
4. Lawyer Referral:_____
5. Case Manager Referral: _____
6. Word of mouth:_____
7. Other (Please specify):_____

Thank You!

Aquatic Solutions Physical Therapy