AQUATIC SOLUTIONS
Physical Therapy

25591 COOLIDGE HWY
OAK PARK, MI 48237
P: (248) 331-9490 F: ( )

PATIENT INFORMATION

NAME:_____ **TODAYS 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 NUMBER:**_____

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

POLICY#:_____ **GROUP#:**_____

PATIENT RELATIONSHIP TO THE INSURED: SELF SPOUSE CHILD OTHER (CIRCLE ONE)
***** 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#**_____

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

Patient Name: _____ Date of Injury:_____

I irrevocably assign all of my rights and benefits under my auto insurance contract to, Aquatic Solutions Physical Therapy, 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 this 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 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: _____

Guardian Signature: _____Date:_____

The undersigned, being the patients 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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HIPPA AUTHORIZATION FOR MEDICAL RECORDS

Consistent with my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 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 HIPPA 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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HIPPA 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 Professional Care 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 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