920 E. Northwest Highway
Mount Prospect, IL 60056
Phone: (847) 459-4779
Fax: (847) 459-5771
www.PDRehab.com

Welcome to PDR Physical Therapy & Wellness Center. This document contains important information about our policies and procedures, which will help us provide you with the best quality care possible. Please read it carefully. Feel free to discuss any questions you have with your therapist. We look forward to helping you with your recovery!

ATTIRE

Please wear clothing that is appropriate to exercise in. The type of exercise you will be performing depends on your diagnosis, but in general you should wear loose clothing that will not restrict your ability to move comfortably and expose the injured area. Athletic shoes and shorts are also recommended for spinal and lower extremity injuries. If you will be arriving directly from work, please bring appropriate attire with you.

APPOINTMENT SCHEDULING

Patient appointments are scheduled every 45 minutes. If all patients arrive promptly for their scheduled sessions there should not be a long wait past your appointment time. ***If you find that you are running late, we request that you call immediately to notify our office.*** We try to be as accommodating as possible, but understand that other patients need to be seen on time as well. If your therapist does not feel that a productive treatment can be provided in the time remaining you may be asked to reschedule. Calling ahead may alleviate this situation. Try to schedule a week in advance to get your desired times.

CANCELLATION POLICY

Together you and your therapist will set your treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions to achieve the best success. If you must cancel or change an appointment, we request that you notify our office a minimum of 24 hours prior to your scheduled appointment time by calling (847)459-4779. If you are a worker's compensation patient, please be advised that your employer, physician and case manager will be notified of each missed appointment. *If you miss/cancel your appointment **3 times** we will discharge you and notify your doctor.* ***If you fail to call to cancel you will be charged $50.00 and lose any future scheduled appointments.*** This charge is not reimbursable by insurance companies and will be your personal responsibility.
I acknowledge that I have read and understand this cancellation policy.

Patient / Guardian Signature ____ Date _______________

CONSENT

I agree to let PDR Physical Therapy & Wellness Center use: ______ pictures/video ______ testimonials for medical documentation and advertisement. I agree to be contacted for this purpose.

Patient / Guardian Signature ____ Date _______________

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PATIENT INFORMATION

<table>
<tr><td colspan="3">Patient's Name (First, Middle, Last)</td><td>D.O.B</td><td>Sex (Circle)
M F</td><td>Cell Phone #</td></tr>
<tr><td colspan="5">Patient's Address City State Zip</td><td>Do you wish to receive text messages with appointment reminders? (Circle)
YES / NO</td></tr>
<tr><td>Social Security # (Worker's Comp.)</td><td colspan="4">Occupation Employer's Name</td><td>Email Address</td></tr>
<tr><td colspan="3">Insured's Name (if different from above)</td><td colspan="2">Insured's D.O.B</td><td>Secondary Contact Phone #</td></tr>
<tr><td colspan="2">Patient's Relationship to Insured (Circle)
Self Spouse Child Other</td><td colspan="3">Patient Status (Circle)
Single Married Other</td><td>Are you a Student?
Yes No</td></tr>
</table>

How did you hear about PDR Physical Therapy & Wellness Center? ______________________________

PATIENT MEDICAL HISTORY

If you have or had any of the following conditions, **please circle the appropriate answer.** If the answer is yes**, please specify** and give approx. **dates**.

Tumor or Cancer (YES or NO) ______________________

Arthritis (YES or NO)______________________

High Blood Pressure (YES or NO) ______________________

Broken Bones (YES or NO) ______________________

Osteoporosis (YES or NO) ______________________

Disabling Headaches (YES or NO) ______________________

Spine Disorders (YES or NO) ______________________

Asthma (YES or NO) ______________________

Paralysis/ Muscle Weakness (YES or NO) ______________________

Diabetes (YES or NO) ______________________

Pregnancy (YES or NO) ______________________

Heart Problems (YES or NO) ______________________

Pacemaker Implantation (YES or NO) ______________________

Other (YES or NO) ______________________

Please list previous surgeries and the year it/they were performed:______________________________

____

Have you had Physical Therapy this year? Yes / No If yes, how many visits? ______________

Have you received ***any medical services*** at home in the last two months? ________ Yes ________ No

CURRENT INJURY INFORMATION

Body part(s) you are being referred to therapy for: ______________________________

Injury Date/Surgery (if applicable) Date: ______________ Please Circle: Work Injury / Auto Accident / Other

Are you taking any medications for your current injury? If so, please list the names or types of medications:______________

____

Patient / Guardian Signature ______________________________ Date ______________

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BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled; including Medicare, Medicaid, private insurance and third party payers, to PDR Physical Therapy & Wellness Center. A photocopy of this assignment is to be considered as valid as the original.
I hereby authorize said assignee to release all information necessary, including medical records, to secure payment. I hereby authorize said assignee to release all information necessary, including medical records, to my physicians and to name: ___________________________________, phone number: ______________________, relationship: __________________________.

Patient / Guardian Signature ____ Date ______________

CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for PDR Physical Therapy & Wellness Center to furnish the medical care and treatment considered necessary and proper in diagnosing and/or treating.

Patient / Guardian Signature ____ Date _____________

PAYMENT NOTICE

Thank you for choosing PDR Physical Therapy & Wellness Center for your therapy needs. The following information is provided to avoid any misunderstanding regarding payment for therapy services.

- Prompt payment allows us to control costs. Outstanding account balances cost both of us time and money. Therefore, during the course of treatment, you are required to pay your co-payment at each visit or minimally weekly.

- PDR Physical Therapy & Wellness Center will assist you in determining if you have a co-payment and how much it is. We accept cash, checks and credit cards.

- If your payment is not received within 30 days after you receive your first statement, and if you have not made financial arrangements with PDR Physical Therapy & Wellness Center at (847)459-4779, you will be contacted.

- All patients refusing to remit payment after 61 days of notice without pending insurance or financial arrangement will result in our turning the account over to an outside collection agency. You will be responsible for 1.5% interest charges accruing monthly and all collection fees up to 40%.

- Our staff is committed to providing you with superior therapy services as well as open communication regarding financial concerns and questions. If you have any questions concerning our policy, please contact us immediately.

Patient / Guardian Signature ____ Date _____________

HIPAA NOTICE OF PRIVACY PRACTICES

I, the undersigned, received from PDR Physical Therapy & Wellness Center their Notice of Privacy Practices.

Patient / Guardian Signature ____ Date ____________