PDR PHYSICAL THERAPY & WELLNESS CENTER

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

PATIENT INFORMATION:

Patient's Name (First, Middle, Last)	D.O.B	Sex (Circle) **M F**	Cell Phone Number
Patient's Address: Street		City	State Zip
Occupation	Email Address:		Secondary Phone Number
Insured's Name (if different from above)	Patient's Relationship to insured (Circle) Self Spouse Child Other		Insured D.O.B
Can we disclose medical information to your emergency contact? (circle) **YES NO**	Patient's doctor name:		Can we send you text messages with appointment reminders? (circle) **YES NO**
Emergency Contact Name	Relationship to Patient		Emergency Contact Phone

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)_____

Heart Problems (YES or NO)_____ Pregnancy - currently (YES or NO) _____

Pacemaker Implantation (YES or NO) _____ Other _____ _____

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 Last visit date_____

CURRENT HEALTH PROBLEM

Main problem you are being referred to therapy for: _____

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

Please list any **medications** you are taking :_____

_____

Patient / Guardian Signature _____ ***Date*** _____

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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!

CONSENT FOR TREATMENT _____ (please initial)
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.

MISSED APPOINTMENTS POLICY _____ (please initial)
If you must cancel or change an appointment, we request that you notify our office a minimum of 24 hours prior to your appointment time. If you fail to call to cancel, you will be charged $50.00 If you miss/cancel your appointment 3 times we will discharge you and notify your doctor. If you find that you are running late, we request that you call our office immediately. We try to be as accommodating as possible, however if your therapist does not feel that a productive treatment can be provided in the time remaining you may be asked to reschedule.
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.

CONSENT FOR PICTURES I agree to let PDR Physical Therapy & Wellness Center use pictures/video and/or testimonials for:

- Medical documentation _____ (please initial)
- Advertisement _____ (please initial)

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION _____(please initial)
I hereby authorize insurance benefits, including Medicare benefits, private insurance and third party payers to be paid directly to PDR Physical Therapy & Wellness Center. A photocopy of this assignment is to be considered as valid as the original. I recognize it is my responsibility to pay for all non covered services.
I hereby authorize PDR Physical Therapy and Wellness Center to release all information necessary, including medical records, to the insurance carrier to determine these benefits and to secure payment.

PAYMENT NOTICE _____(please initial)
PDR Physical Therapy & Wellness Center will assist you in determining if you have any deductible, co-payment or co-insurance to pay based on your insurance benefits. Prompt payment allows us to control costs. During the course of treatment, you are required to pay, if you have any, your co-payment at each visit or minimally weekly. We accept cash, checks and credit cards. Your payment is due within 30 days after you receive your first statement; If payment is not received after 90 days and you don't have pending insurance or financial arrangement with our billing office, your account will be turned over to an outside collection agency. You will be responsible for 1.5% interest charges accruing monthly and all collection fees up to 40%. If you have any questions concerning our policy, please contact us immediately.

HIPAA NOTICE OF PRIVACY PRACTICES _____(please initial)
I, the undersigned, received from PDR Physical Therapy & Wellness Center their Notice of Privacy Practices.

Upon signing this consent, I acknowledge that I have read and understand the foregoing and accepted its terms.

Patient name _____

Patient/ guardian signature_____ date _____