

3920 E Northwest Hwy, Mount Prospect, IL 60056 Phone: 847-459-4779; Fax: 847-459-5771

www.PDRehab.com

PATIENT INFORMATION:

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Patient's Name (First, Middle, Last)	D.O.B	Sex (Circle)	Cell Phone Number
		MF	
Patient's Address: Street	City		State Zip
Occupation	Email Address		Secondary Phone Number
Insured's Name (if different from above)	Patient's Relationship Self Spouse	to insured (Circle) Child Other	Insured D.O.B
Can we disclose medical information to your emergency contact? (circle) YES NO	Patient's Doctor Name		Can we text you 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) Disabling Headaches (YES or NO)_____ Osteoporosis (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:______ If yes, how many visits? Have you had physical therapy this year? Yes / No 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

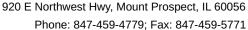


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Welcome to PDR Physical Therapy & Wellness Center

This document contains important inform	•		, ,		
best quality care possible. Please read	•	to discuss any questions ye	ou have with your therapist. We		
look forward to helping you with your re-	covery!				
CONSENT FOR TREATMENT I, the undersigned, do hereby agree and medical care and treatment considered	d give my consent for				
CONSENT FOR PICTURES I agree to testimonials for:	let PDR Physical The	rapy & Wellness Center us	se pictures/video and/or		
Medical documentation	(please initial)	Advertisement	(please initial)		
BENEFIT ASSIGNMENT / RELEASE Colline of the second of the	ncluding Medicare be	nefits, private insurance ar	nd third-party payers to be paid		
directly to PDR Physical Therapy & Wel original. I recognize it is my responsibilit			to be considered as valid as the		
I hereby authorize PDR Physical Therap			n necessary including		
medical records, to the insurance carrie					
		, ,			
PAYMENT NOTICE(p	olease initial)				
PDR Physical Therapy & Wellness Cen					
co-insurance to pay based on your insur			_		
treatment, you are required to pay, if you		-			
checks, and credit cards. Your payment	-				
received after 90 days and you don't ha	•	_	•		
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.					
an concention lees up to 4070. If you have	, any questions conce	criming our policy, pieuse of	shade as ininiculately.		
CANCELLATION / NO SHOW POLICY (please initial)					
I, the undersigned, have read and unde			agree to its terms.		
-		-			
HIPAA NOTICE OF PRIVACY PRACTIC	CES	_(please initial)			
I, the undersigned, received from PDR I	Physical Therapy & W	Vellness Center the Notice	of Privacy Practices.		
Upon signing this consent, I acknowle	edge that I have rea	nd and understood the fo	regoing and accepted its		
terms. Patient name					
Patient/ guardian signature		date			



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CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to PDR Physical Therapy & Wellness Center. We are committed to providing the utmost in medical care and ensuring that our patients receive the care they need and deserve. To maintain a high standard of care and affordable costs of services, we ask our patients to review and adhere to our cancellation policy.

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and <u>no later than</u> <u>24 hours</u> prior to your scheduled visit (24 hours from the time of your visit, <u>not a day</u> before). This gives us time to schedule other patients who may be waiting for treatment. To cancel or reschedule your appointment, please call or text one of the following numbers:

Main line: (847) 459 4779

Front desk (direct line): (224) 333 1282

Mobile (if other lines do not work): (224) 523 6404

A message can always be left on our voice mailbox to avoid a cancellation fee being charged.

- Effective May 1, 2022, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a no-show and **charged a \$50.00 fee.**
- Any established patient who fails to show or cancels/reschedules a visit with no 24-hour notice a second time will be charged a \$100.00 fee.
- If a patient cancels or reschedules for a third time without notifying us 24 hours in advance, a **full appointment fee of \$140 will be charged.** After three consecutive no-shows, we reserve the right to terminate treatment.
- If you are a worker's compensation patient, please be advised that your employer, physician, and case manager will be notified of each missed visit.
- Any new patient who fails to show up for their initial visit will not be rescheduled unless a no-show fee of \$160 is paid before the next appointment.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- If an appointment is scheduled on Monday or a day immediately following a holiday, it must be canceled on the last business day before the holiday.
- As a courtesy, when time allows, we make reminder calls or texts. Please note, that if a reminder call or message is not received, the cancellation policy still remains in effect.
- 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 your visit.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. In such a circumstance, **consideration will be given and a one-time exception may be granted.**