PDR PHYSICAL THERAPY & WELLNESS CENTER

3920 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 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) _____

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.

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 not 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.

CANCELLATION / NO SHOW POLICY _____ *(please initial)*
I, the undersigned, have read and understood the **Cancellation/No Show Policy** and agree to its terms.

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

Upon signing this consent, I acknowledge that I have read and understood the foregoing 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 **no later than 24 hours** prior to your scheduled visit **(24 hours from the time of your visit, not a day 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.**