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 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) __________________________

High Blood Pressure (YES or NO) _______________________

Osteoporosis (YES or NO) _____________________________

Spine Disorders (YES or NO) ___________________________

Paralysis/ Muscle Weakness (YES or NO) ________________

Heart Problems (YES or NO)____________________________

Pacemaker Implantation (YES or NO) ____________________

Arthritis (YES or NO)___________________________

Broken Bones (YES or NO) _____________________

Disabling Headaches (YES or NO)_______________

Asthma (YES or NO) ___________________________

Diabetes (YES or NO)___________________________

Pregnancy - currently (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

The main problem you are being referred to therapy for: ____

Is your condition related to any injury: *(Please Circle*) Yes ____ No_____

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 ask 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 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)*
I understand this is my responsibility to know and understand my insurance policy terms and conditions. PDR Physical Therapy & Wellness Center may assist a patient in determining whether the policy requires the payment of co-pays or other fees, however, **it is not the responsibility of the clinic's employees.**
Prompt payment allows us to control costs. During treatment, you are required to pay, if you have any, your co-payment at each visit or minimally weekly. 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 arrangements 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%.

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 _____________________