



INTRODUCTION AND PATIENT INFORMATION

Welcome and thank you for choosing Therapeutic & Wellness Specialists!

It is our mission to provide each patient with the best possible therapy experience while in our care. At Therapeutic & Wellness Specialists we are most interested in helping you achieve your therapy goals as efficiently as possible. The following outline describes clinic policies which are necessary for good patient care. Should you have any questions feel free to ask our general manager or your therapist.

Initial Evaluation: During your first visit your therapist will perform an initial evaluation to

- (1) Establish those physical problems which can be addressed by therapy
- (2) Provide an assessment of your current status
- (3) Set short and long term goals for your participation in therapy.

A report of the initial evaluation will be sent to your physician for his/her review.

Communication: We do not discriminate against any language, hearing or visual impairments. Make the staff aware of any hearing, language or visual deficits that may make instructions difficult for you to understand. Let us know how we can best assist improve our communications with you. For instance, all written material can be made available in large print.

Schedule: We will make every effort to book appointments around your schedule. However, appointments are scheduled on a first come first served basis. Because there are times which are more popular we ask you to schedule appointments at least two (2) weeks out so we can best accommodate you.

Cancellations: We require a **24 hour notice** should you need to cancel an appointment. While emergencies do occur, we ask you to make every effort to abide by this policy. A \$50 cancellation fee will be assessed when appropriate notice is not given. Attendance is important to the success of your treatment - if you exceed three (3) cancellations we require an updated prescription from your physician prior to returning to therapy.

Charges: Insurance **co-payment is due on the day of treatment.** For your convenience, we directly submit charges for treatment to your insurance for reimbursement. However, your insurance may pay only a portion of the fee making you responsible for the balance of your bill. Many insurance carriers also limit the number of treatments; it is your responsibility to secure this information before treatment.

Discharge: Patients can be discharged for the following:

1. Therapy and/or wellness goals have been satisfied.
2. Patient has not returned to therapy for one (1) month or is chronically late.
3. Patient has been negligent in cooperating with his/her plan of care including the home exercise program.
4. Patient's condition has changed and patient has been sent back to his/her physician for additional medical intervention.

Therapeutic & Wellness Specialists LLC does not discriminate against any person on the basis of race, color, national origin, disability or age in admission, treatment, or participation in its programs, services and activities. Again, thank you for choosing us to provide for your therapy and wellness needs!

Patient or Personal Representative Signature and Date

Witness and Date

GET WELL

BE WELL

STAY WELL



480 Elm Place, Suite 103
Highland Park, IL 60035
(847)926-9355

Notice of Private Practices/HIPAA – SUMMARY

This is a summary of the **NOTICE of PRIVATE PRACTICES**, describing how medical information about you may be used and disclosed, and how you can get access to this information. **PLEASE REVIEW IT CAREFULLY.**

The law requires that this office maintain the privacy of your medical information, and that we furnish you with a copy of this notice. Should you wish to receive a copy of the Notice of Privacy Practices in its entirety; a copy will be made available to you upon request.

Your medical information will be used for treatment purposes, and this office will send written documentation to your physician regarding objective clinical information related to your diagnosis and your treatment.

Therapeutic & Wellness Specialists, LLC will provide clinical information regarding your diagnosis and treatment as requested by your insurance company or designated agent to evaluate your claims and provide reimbursement for services rendered.

Your medical information will be used for other health care operations, including evaluation of our treatment services; to contact you regarding health care issues, appointment notifications, and to request payment.

Therapeutic & Wellness Specialists, LLC may use your medical information for additional uses as required/requested by law; other disclosures made only with your written consent.

You have the following rights regarding your medical information: Right to receive our completed Notice of Privacy and Practices; Right to request restrictions on disclosures of your medical information; Right to request amendments to your medical information; Right to an accounting of disclosures of your medical information

If you feel that your privacy rights have been violated, please contact our General Manager at 847-926-9355, or in writing at 480 Elm Place, Suite 103, Highland Park, IL 60035, or contact the U. S. Secretary of Health and Human Services.

I hereby authorize by my signature that I acknowledge receipt and understanding of the Notice of Private Practices

SIGNATURE of PATIENT or PERSONAL REPRESENTATIVE

DATE

WITNESS

GET WELL

BE WELL

STAY WELL



Patient Registration

Today's Date:		
Patient's Name:		
Street Address:		
City:		
State:		
Zip:		
Home Phone:	Work Phone:	
Mobile Phone:	Which phone number would you prefer we use? (circle one) Home Work Mobile	
Email Address:		
Birth date:		
Referring Physician:	Referring Physician's Phone Number:	
Medicare/Insurance: (please present your card for photocopying)		
Is insurance in your name: (circle one) Yes No		
If no, in whose name is the insurance:		
Relationship to patient:		
In case of emergency please call:		
Name:		
Telephone number:		
Relationship to patient:		
For Office Use Only		
Date of visit:		
MD Dx:		
Medical ICD-9:		
Treatment ICD-9:		
PT:		

GET WELL BE WELL STAY WELL



Patient Medical History

Patient Name:	
Date of Birth:	Gender: (circle one) Male Female
Are you: (circle one) Right-handed Left-handed	
Language you speak most often? Interpreter needed?	
Current Condition(s)/Chief Complaint(s)	
a) Describe the problem(s) for which you seek physical/occupational therapy:	
b) When did the problem(s) begin: (date)	
c) Have you ever had the problem(s) before? (circle one) NO YES	
If yes... c1) What did you do for the problem(s)?	
c2) Did the problem(s) get better? (circle one) YES NO	
c3) How long did the problem(s) last?	
d) How are you taking care of the problem(s) now?	
e) What makes the problem(s) better?	
f) What makes the problem(s) worse?	
g) What are your goals for physical/occupational therapy?	
h) Are you seeing another medical professional for this problem? If so, please list.	
Functional Status/Activity Level (check all that apply)	
<input type="checkbox"/> Difficulty with activities of daily living? <input type="checkbox"/> Transfers (such as moving from bed to chair, from bed to commode) <input type="checkbox"/> Walking <input type="checkbox"/> On level surface <input type="checkbox"/> On stairs <input type="checkbox"/> On ramps <input type="checkbox"/> On uneven terrain <input type="checkbox"/> Difficulty with sit to stand?	
Medications	
List all prescription medications you are taking:	
List all non-prescription medications you are taking: (such as, aspirin, herbal supplements, etc.)	
Social History	
Any customs or religious beliefs or wishes that might affect care?	
Employment/work	
<input type="checkbox"/> Working full-time <input type="checkbox"/> Working part-time	

GET WELL **BE WELL** STAY WELL



What is your occupation? _____		
<input type="checkbox"/> Student	<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed
General Health Status		
Please rate your health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Social/Health Habits		
<i>Smoking</i>		
Currently smoke tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>Exercise</i>		
Do you exercise on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical/Surgical History		
Check if you have ever been diagnosed with...		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Parkinson disease
<input type="checkbox"/> Broken bones/fractures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizures/epilepsy
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Diabetes/high blood sugar	<input type="checkbox"/> Allergies
<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Circulation/vascular problems	<input type="checkbox"/> Head injury	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Kidney problems
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin diseases	<input type="checkbox"/> Depression
<input type="checkbox"/> Ulcers/stomach problems	<input type="checkbox"/> Infectious disease (hepatitis, tuberculosis, etc.)	<input type="checkbox"/> Other (please indicate)
Within the past year, have you had any of the following symptoms? (check all that apply)		
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Weight gain/loss
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Joint pain or swelling	<input type="checkbox"/> Fever/chills/sweats
<input type="checkbox"/> Chronic cough/hoarseness	<input type="checkbox"/> Pain at night	<input type="checkbox"/> Headaches
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Dizziness or blackouts	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Weakness in arms or legs	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Other (please indicate)
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Difficulty swallowing	_____
Have you had any of the following for your current condition? (If Yes, check all that apply)		
<input type="checkbox"/> Angiogram	<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Pulmonary function test
<input type="checkbox"/> Biopsy	<input type="checkbox"/> EEG (electroencephalogram)	<input type="checkbox"/> Spinal tap
<input type="checkbox"/> Blood tests	<input type="checkbox"/> EKG (electrocardiogram)	<input type="checkbox"/> Stress test
<input type="checkbox"/> Bone scan	<input type="checkbox"/> EMG (electromyogram)	<input type="checkbox"/> X-rays
<input type="checkbox"/> Bronchoscopy	<input type="checkbox"/> MRI	<input type="checkbox"/> Other (please indicate)
<input type="checkbox"/> CT scan	<input type="checkbox"/> Myelogram	
<input type="checkbox"/> Doppler ultrasound	<input type="checkbox"/> NCV (nerve conduction velocity)	

I certify that, to the best of my knowledge, all the information above is accurate.

SIGNATURE of PATIENT or PERSONAL REPRESENTATIVE

DATE

PT/OT INITIALS

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