



P D REHAB, INC.

Physical Therapy & Wellness Center

Prospect Heights / Bloomingdale / Chicago * Phone: (847) 459-4779 * Fax: (847) 459-5771

www.PDRehab.com

Welcome to P D Rehab, Inc. 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!

Appointment Scheduling

Patient appointments are scheduled every 45 minutes. If all patients arrive promptly for their scheduled sessions there should not be a long wait past your appointment time. ***If you find that you are running late, we request that you call immediately to notify our office.*** We try to be as accommodating as possible, but understand that other patients need to be seen on time as well. If your therapist does not feel that a productive treatment can be provided in the time remaining you may be asked to reschedule. Calling ahead may alleviate this situation. Try to schedule a week in advance to get your desired times.

Cancellation Policy

It is important for your recovery that all appointments be attended. If you are unable to keep an appointment, we ask that you give us advance notification, preferably 24 hours in advance. This allows us to fill your appointment time with patients on our waiting list. **If you miss/cancel your appointment 3 times we will discharge you and notify your doctor.** ***If you fail to call to cancel you will be charged \$50.00 and lose any future scheduled appointments.*** This charge is not reimbursable by insurance companies and will be your personal responsibility. We are aware that occasionally circumstances may arise which are beyond your control, and these special cases can certainly be discussed with your therapist. Worker's compensation patients please take note that we must immediately notify your insurance representative, employer, physician, and rehab nurse of any missed appointments.

Attire

Please wear clothing that is appropriate to exercise in. The type of exercise you will be performing depends on your diagnosis, but in general you should wear loose clothing that will not restrict your ability to move comfortably and expose the injured area. Athletic shoes and shorts are also recommended for spinal and lower extremity injuries. If you will be arriving directly from work, please bring appropriate attire with you.



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PATIENT INFORMATION

Patient's Name (First, Middle, Last)		D.O.B	Sex(Circle) M F	Phone #
Patient's Address		City	State Zip	EMAIL ADDRESS
Social Security #	Occupation	Employer's Name		Employers Phone #
Insured's Name (if different from above)		Insured's D.O.B		Cell Phone #
Insured's Address		City	State Zip	Insured's Phone #
Employed? Yes No	Insured's Occupation	Insured's Employer's Name		Employer's Phone #
Patient's Relationship to Insured (Circle) Self Spouse Child Other		Patient Status (Circle) Single Married Other		Are you a Student? Yes No

PATIENT MEDICAL HISTORY

*If you have or had any of the following conditions, **please circle** and give approximate **dates** or indicate "**current**".*

Tumor or Cancer _____ Arthritis _____

High Blood Pressure Problems _____ Broken Bones _____

Osteoporosis _____ Disabling Headaches _____

Spine Disorders _____ Asthma _____

Paralysis or Muscle Weakness _____ Diabetes _____

Pregnancy _____ Heart Problems _____

Pacemaker Implantation _____ Other _____

Please list all previous surgeries and the year performed: _____

CURRENT INJURY INFORMATION

Body part(s) you are being referred to therapy for: _____

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

Are you taking any medications for your current injury? If so, please list the names or types of

medications: _____



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PAYMENT NOTICE

Thank you for choosing P D Rehab, Inc. for your therapy needs. The following information is provided to avoid any misunderstanding regarding payment for therapy services.

- Prompt payment allows us to control costs. Outstanding account balances cost both of us time and money. Therefore, during the course of treatment, you are required to pay your co-payment at each visit or minimally weekly.
- P D Rehab, Inc. will assist you in determining if you have a co-payment and how much it is. We accept cash, checks and credit cards.
- Your insurance coverage is an agreement between you and your insurer. As a courtesy, P D Rehab will submit your claims to your insurance carrier. It is your responsibility to assist in following up with your insurance carrier if they do not pay your claims in a timely manner; and to remit payment directly to P D Rehab, Inc. for charges not covered by your policy.
- If a problem occurs with your claims, you will be required to establish written financial arrangements with our company until your insurance problem is resolved.
- If your payment is not received within 30 days after you receive your first statement, and if you have not made financial arrangements with P D Rehab at (847)459-4779, you will be contacted.
- All patients refusing to remit payment after 61 days of notice without pending insurance or financial arrangement will result in our turning the account over to an outside collection agency. You will be responsible for 1.5% interest charges accruing monthly and all collection costs.
- Our staff is committed to providing you with superior therapy services as well as open communication regarding financial concerns and questions. If you have any questions concerning our policy, please contact us immediately.

Patient/Guardian Signature

Date



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BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled; including Medicare, Medicaid, private insurance and third party payers, to P D Rehab, Inc. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment. I hereby authorize said assignee to release all information necessary, including medical records, to my physicians.

Patient / Guardian Signature _____ Date _____

CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for P D Rehab, Inc. to furnish medical care and treatment to _____, considered necessary and proper in diagnosing or treating his / her physical condition.

Patient / Guardian Signature _____ Date _____

CANCELLATION POLICY

Together you and your therapist will set your treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions to achieve the best success. If you must cancel or change an appointment, we request that you notify our office a minimum of 24 hours prior to your scheduled appointment time by calling (847)459-4779. 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. ***If you miss/cancel your appointment 3 times we will discharge you and notify your doctor. If you fail to call to cancel you will be charged \$50.00 and lose any future scheduled appointments.*** This charge is not reimbursable by insurance companies and will be your personal responsibility. I acknowledge that I have read and understand this cancellation policy.

Patient / Guardian Signature _____ Date _____



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

P D Rehab, Inc is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or health care operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with P D Rehab, Inc."

"It is our policy to provide a substitute health care provider, authorized by P D Rehab, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to P D Rehab, Inc. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

“As a courtesy to our patients, we may call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of P D Rehab, Inc. sponsored fund-raising events.”

Change of Ownership

In the event that P D Rehab, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that P D Rehab, Inc. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that P D Rehab, Inc. amend your protected health information. Please be advised, however, that P D Rehab, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by P D Rehab, Inc.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

P D Rehab, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, P D Rehab, Inc. is required by law to comply with this Notice.

P D Rehab, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact Peter Domagala, PT by calling this office at (847)459-4779. If Peter Domagala is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how P D Rehab, Inc. has handled your health information should be directed to Peter Domagala, PT by calling this office at (847)459-4779. If Peter Domagala is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide P D Rehab, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient’s Name (print)

Patient’s Signature

Date

Authorized Facility Signature

Date