NORTHWEST
— WELLNESS —

Welcome to Northwest Wellness!

1614 W. Central Rd., Ste. 208, Arlington Heights, IL 60005

Tel.: (847) 481-6077 |Fax: (847)929-9036
nwwellnessgroup@gmail.com

For the Practice's use.
☐ Self-referral *or*
☐ Referring provider:
____
Vitals at intake:
HR_______ BP________

Please complete these intake forms before your first appointment and return them via email. Please reach out with any questions, and we look forward to meeting you.

Basic Biographical Information

DEMOGRAPHIC INFORMATION.

Name: ____________________

Date of birth: ____________________

Mailing address: ____________________

____

Relationship status: __________ Sex: _______

SSN: ____________________

WHO IS YOUR PRIMARY CARE DOCTOR?
Name: ____________________
City/state: ____________________

HOW CAN WE CONTACT YOU?

Phone number: ____________________

OK to leave voicemail? ☐*Yes.* ☐*No.*

Email address: ____________________

OK to send you emails? ☐*Yes.* ☐*No.*

WHO IS YOUR EMERGENCY CONTACT?

Name: ____________________

Phone number: ____________________

Relationship: ____________________

Helpful Health Information

Do you get regular physicals? ☐Yes. ☐No.
Do you feel like you're in generally good health? Please discuss.

What medications do you take and please include frequently used dietary supplements and non-prescription medications? ***You may also bring a pre-printed list.***

Name: ____________________ Reason: ____________________

Name: ____________________ Reason: ____________________

Name: ____________________ Reason: ____________________

Name: ____________________ Reason: ____________________

Name: ____________________ Reason: ____________________

Name: ____________________ Reason: ____________________

HEALTH HISTORY. *Check and describe any health conditions you experience(d):*

☐ Asthma, Bronchitis, Emphysema, COPD
☐ Stroke, TIA
☐ Pacemaker or defibrillator
☐ High blood pressure
☐ Osteoarthritis
☐ Infectious diseases
☐ Severe, frequent headaches
☐ Allergies /______________________________
☐ Joint replacement / ______________________
☐ Cancer / ________________________________
☐ Mental health / ___________________________
☐ Cardiovascular disease / ___________________
☐ Sexual transmitted disease / ________________
☐ Dizziness, fainting
☐ Hernia
☐ Epilepsy, seizures
☐ Thyroid problems
☐ Bowel, bladder problems
☐ Endometriosis
☐ Low back pain
☐ Neck pain
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Osteoporosis
☐ Diabetes
☐ Vision or hearing problems
☐ Other: ____

SURGICAL HISTORY. Have you ever had surgery? Yes. No.

Date: ________________ Reason: ____
Date: ________________ Reason: ____
Date: ________________ Reason: ____
Date: ________________ Reason: ____
Date: ________________ Reason: ____

FOR WOMEN.

Do you get regular periods? ☐ Yes. ☐No. Are your periods painful? ☐ Yes. ☐ No.
Could you be pregnant? ☐ Yes. ☐ No.
Are you trying to get pregnant? ☐Y es. ☐ No.
If so, are you using assisted fertility treatments? ☐ Yes. ☐ No.
Pregnancies #: _______ / Births #: _______.(vaginal #: _____ / c-section #: _____)

Do you feel safe from violence, coercion, and abuse at home? ☐Yes. ☐ No.
If not, we can direct you to social service agencies that can assist you. It's safe to tell us.

We will rely upon the information you have provided in treating you. By signing below, you attest that this information is accurate to the best of your knowledge.

____
Patient Name

____ ______________
Patient Signature Date

____ ______________
Guardian Signature (for dependent patients) Date

For the Practice's use. I reviewed these forms in-person with the patient and understand the reason for the patient's presentation in the clinic. *Initials:* ______________ *Date:* ____________

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Our Practice Policies

Please review these policies and initial to indicate your consent.
If you have questions, please ask!

Examination of Health Records

To receive a copy of your health records, please provide your written request and authorization to the address listed on this form. Please note that copy, postage, shipping, scanning, and digital storage device fees may apply.

I have read and understand this examination of healthcare records policy and agree to be bound by its terms.

Client initials: ______

Cancellation

We understand that you are busy and that your schedule may change. So if you need to cancel or reschedule your appointment, you may do so with at least 24-hours advance notice with no charge. You may cancel or reschedule by calling the number on this form (you may leave a message). Because appointments are in high demand, you will be charged a **$50.00 fee** for missing a scheduled appointment or cancelling or rescheduling within 24 hours. Your insurance company likely will not cover this charge, and failure to cancel in advance of the appointment time will result in the visit being classified as a "no show" in our records.

I have read and understand this cancellation policy and agree to be bound by its terms.

Client initials: ______

Self-Payment for Services

If you do not have insurance or you do not want us to bill your insurance, you may pay us directly at the time of service. This means that payment is due at the time of your appointment. If we have not collected or verified your insurance information, then we do not guarantee that you can receive partial reimbursement from any third-party for our fees. You agree to pay any bank fees for returned checks.

If you later decide to file claims for reimbursement with your insurance company, it may not cover these services, or it may consider them to be out-of-network. If you decide to do this, we will provide the documentation necessary so long as you request that documentation within 6 months of the date of the appointment to which it pertains.

I have read and understand the Practice's self-pay services policies, and I agree to be bound by their terms. I understand I am personally responsible for all fees.

Client initials: ______

Privacy

The Practice maintains strict privacy policies, and you have been given or offered a copy of our Notice of Privacy Practices, which summarizes the detailed policies and procedures that we implement to protect your personal health information.

I have been offered a copy of the Notice of Privacy Practices, and I agree to be bound by its terms.

***Client initials:* ______**

Indemnification & Assumption of Risk

As a condition of receiving our services, you agree to indemnify us against all claims, liabilities, losses, damages, suits, costs, and expenses, including reasonable attorney's fees, relating to our services to you, except to the extent that such a claim is caused by our gross negligence or willful misconduct. Furthermore, you agree to assume all risk of property damage, injury, and/or death associated with the services that we provide to you. The terms of indemnification and assumption of risk shall survive the expiration of this agreement.

I have read and understand this policy and agree to be bound by its terms.

***Client initials:* ______**

Insurance & Medicare

If you would like us to bill your insurance (or Medicare) please complete the following:

Insurance company name: ______________________________ ID: ______________
Group number: ____________________ Insured's name: ____________________
Relationship to patient: ______________ Insured's date of birth: ______________
Insured's phone number: ______________ Insured's address: ☐ Same as patient *or* ☐ other:
____

Secondary insurance company name: ______________________ ID: ______________
Group number: ____________________ Insured's name: ____________________
Relationship to patient: ______________ Insured's date of birth: ______________
Insured's phone number: ______________ Insured's address: ☐ Same as patient or ☐ other:
____

No Guarantee of Benefits: If we are in-network for your health plan, we will bill your health insurance company directly for our services. Verifying your insurance coverage and benefits is your responsibility. If we are out-of-network with your plan but you have out-of-network health insurance coverage, upon your request, we will provide the documentation necessary so that you may submit a claim to your insurer. You are responsible for paying any amount that your insurance company does not pay, which may be 100% of our fees.

Contracted Rate: If your provider is in-network with your insurance, your provider has agreed to a rate with your insurance company. Your provider cannot charge you for the difference between the fees listed in our Fee Schedule and the fee covered by your insurance. You will always be responsible for the co-pay and/or any deductible amount required by your insurance.

I have read and understand this policy and agree to be bound by its terms.

***Client initials:* ______**

Payment Guarantee - Credit Card

As a courtesy, we'll bill your insurer for our services. But if for any reason it does not pay in full, or it does not timely do so, you are responsible for full payment. If your insurer has not paid us within 60-days of submission of your bill, we'll let you know, so that you may contact your insurer directly. This means that even if we bill your insurance, you are responsible for any fees that it does not pay, including any deductible, co-pay, co-insurance, and credit card or bank fees. Also, some of our fees, such as the cancellation fee, will not be billed to your insurer and will be your sole responsibility to pay. Accordingly, please compete the following credit card authorization to cover any above described fees.

Name on Card: ________________________ Phone: ______________ Email: ______________
Type of Card: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other: ____________________
Card Number: ____________________________________ Exp. Date: ________ CVC: _____
Card Billing Address (Street/City/State/Zip): ____________________________________
____

Agreement & Acknowledgment

As provided in these policies, by signing below, I agree, acknowledge, and authorize that:

- ✓ I have completed this form truthfully and to the best of my knowledge.
- ✓ I am bound by the Practice's policies.
- ✓ I am bound to indemnify the Practice and voluntarily assume all risk.
- ✓ Northwest Wellness Group LLC to charge my credit card as described above. I further affirm that I am authorized to use this credit card and will not dispute any charge for services rendered, and this authorization is valid until canceled in writing.

______________________________ ____________
Signature Date

If you are under the age of 18, please have your parent/guardian review and sign.

___________________________ __________
Parent/guardian Signature Date

Thank you for reviewing our policies!
We look forward to answering any questions that you may during your first visit!

For the Practice's use.
☐ Patient offered opportunity to ask questions.
☐ Patient offered copy of Notice of Privacy Practices: ☐ *accepted, or* ☐ *declined*
☐ *Minor Patient:* Release signed by parent/guardian.
Initials of reviewing clinician: ______ Date: ________

INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

You will complete this form with your provider at the first visit.

I, ___________________________, acknowledge that Northwest Wellness Group, LLC, its owners, agents, or employees (the "Practice") will provide the following physical therapy services ("PT Services").

For the Practice's use. *Describe: (1) PT services to be rendered, (2) material risks and benefits of these services, and (3) information about alternatives.*

I further acknowledge that:

- ✓ These PT Services and their material risks and benefits have been explained to me;
- ✓ These PT Services may not have the result that I expect, and I have been informed as to other possible services that may provide me a benefit;
- ✓ PT Services are not an exact science, and that I have not been given any guarantees about the result; and
- ✓ I have had ample opportunity and time to discuss my concerns with the Practice or any healthcare provider, and all my questions have been answered to my satisfaction.
- ✓ To facilitate evaluation of my condition, it may be necessary for a provider of the Practice to perform an internal pelvic floor exam, both during the initial evaluation and throughout treatment.
- ✓ I have may have a second person present in the exam room during treatment, but it is my responsibility to bring such person, and the Practice does not have staff available for this purpose.
- ✓ By signing below, I hereby provide my informed consent to receive PT Services as described above.

___________________________________ ______________

Signature Date

Authorization for Use or Disclosure of Protected Health Information for Payment and Insurance Claims Processing and Coordination of Care Purposes

I, ____________________________, voluntarily authorize the Practice's disclosure and use of my protected health information contained in *(check one)* ☐ my health record, or ☐ my dependent's health record, and other private information to the extent necessary for the Practice to obtain payment and submit claims on my behalf to my insurance company or other third-party payor, AND to the extent necessary to coordinate care with my primary care physician or other treating provider.

Agreement & Acknowledgment

I agree and acknowledge that: my insurance company, or other third party payor, may make payments directly to the Practice and assign the Practice any medical benefits to which I may be entitled, including any benefit under Employee Retirement Income Security Act of 1974 (ERISA) in consideration for the services provided; and the Practice may communicate with the primary insured and release the information as necessary to facilitate payment if I am not the primary beneficiary of the above insurer or third-party payer.

Information regarding schedule changes, billing, health information may be disclosed (check all that apply):

☐ To me by: ☐ phone, ☐ voicemail, ☐ text message, or ☐ other: ______________________________
☐ To a family member by: ☐ phone, ☐ voicemail, ☐ text message, or ☐ other: ____________________

Signature of Party Authorizing Release

You may revoke this authorization at any time by providing written notice to the Practice.

____
Patient Printed Name

______________________________ ______________
Patient Signature Date

______________________________ ______________
Guardian Signature (for dependent patients) Date

______________________________ ______________
Witness Signature, the Practice 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.

Patient Rights

You have the right to:

- ✓ Get a copy of your paper or electronic medical record
- ✓ Correct your paper or electronic medical record
- ✓ Request confidential communication
- ✓ Ask us to limit the information we share
- ✓ Get a list of those with whom we've shared your information
- ✓ Get a copy of this privacy notice
- ✓ Choose someone to act for you
- ✓ File a complaint if you believe your privacy rights have been violated

Patient Choices

You have some choices in the way that we use and share information as we:

- ✓ Tell family and friends about your condition
- ✓ Provide disaster relief
- ✓ Include you in a hospital directory
- ✓ Provide mental health care
- ✓ Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- ✓ Treat you
- ✓ Run our practice
- ✓ Bill for your services
- ✓ Help with public health and safety issues
- ✓ Do research
- ✓ Comply with the law

- ✓ Respond to organ and tissue donation requests
- ✓ Address workers' compensation, law enforcement, and other government requests
- ✓ Respond to lawsuits and legal actions

Patient Rights: In Detail

When it comes to your health information, you have certain rights.

1. **Get an electronic or paper copy of your medical record**: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

2. **Ask us to correct your medical record**: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

3. **Request confidential communications**: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

4. **Ask us to limit what we use or share**: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

5. **Get a list of those with whom we've shared information**: You can ask for a list (called an "accounting") of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

6. **Get a copy of this privacy notice**: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

7. **Choose someone to act for you**: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

8. File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

PATIENT CHOICES: IN DETAIL

You can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

1. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, share information in a disaster relief situation, and include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

2. In these cases, we never share your information unless you give us written permission: Marketing purposes, sale of your information, and most sharing of psychotherapy notes.

OUR USES & DISCLOSURES: IN DETAIL

We typically use or share your health information in the following ways.

1. Treat you: We can use your health information and share it with other professionals who are treating you.

2. Operate our practice: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

3. Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

4. How else we use or share your health information: We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

5. Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect,

or domestic violence; and preventing or reducing a serious threat to anyone's health or safety.

6. **Do research:** We can use or share your information for health research.

7. **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

8. **Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.

9. **Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you: for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.

10. **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.htm

Other Information About This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

- This notice is effective on: August 1, 2017
- Chief Privacy Officer is: Rosie Radford