NORTHWEST
— WELLNESS —

Welcome to Northwest Wellness!

1614 W. Central Rd., Ste. 200, 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 / _____
☐ Other: _____

☐ 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

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:* _____

NORTHWEST
— WELLNESS —

Our Practice Policies

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

Privacy and 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. The Practice maintains strict privacy policies. Your signature below confirms that 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.

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 consider them out-of-network. If you decide to do this, we will provide the documentation necessary so long as you request that documentation within six months of the date of the appointment to which it pertains.

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 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. By signing below, I have read and understood this policy and agree to be bound by its terms.

_____ _____

Signature Date

NORTHWEST
— WELLNESS —

Cancellation and No-Show Policy

Please read the following policy on cancellation and no-show appointments carefully.

We have reserved a one-on-one 60-minute appointment for you in order to provide the consistent and high quality of care we are known for here at Northwest Wellness Group. Any missed appointments are a significant inconvenience to your physical therapy plan of care, which was prescribed by your physician or physical therapist, as well as for the clinic, and other patients.

If you are unable to come into the clinic for your session, our first approach is to schedule a Telehealth appointment on the same day and time as the original in-person session.

A 24-hour notice of cancellation or change in your appointment is required via telephone call to our office. Patients who do not call and provide a 24-hour notice will be charged a $125.00 cancellation fee. This charge cannot be billed to insurance companies and must paid on or before the next scheduled appointment.

You are granted 1 missed appointment (no call/no-show/OR cancellation with less than a 24-notice). After that you will be charged a $125.00 fee. Office staff keep track of missed appointments.

Frequent "timely cancellations" (notice of cancellation given greater than 24 hours) will be closely monitored and recorded: missing more than 20% of your sessions, even if they are timely cancellations are subject to be charged the "frequent cancellation" fee of $125.00. Additionally, your time slots may be subject to change. It is up to your therapist's discretion to continue your physical therapy should cancellations occur frequently.

Please be aware that therapists are paid hourly. Most receive compensation only when clients attend therapy sessions. Their time is valuable and our services are in high demand. Therefore, these safeguard policies are put in place for them and our patients. We appreciate your understanding.

_____	_____	_____
Patient Signature	Print Name	Date
_____	_____	_____
Physical Therapist Signature	Print Name	Date

NORTHWEST
— WELLNESS —

Insurance and 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, we will provide the documentation necessary upon your request 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 maybe 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 any deductible amount required by your insurance.

Payment Guarantee – Credit Card

Name on card: _____ Relation (if not yours): _____

Card billing phone: _____Cardholder email: _____

Card billing address: _____
Street Address City State Zip

Type of Card: ☐ Visa ☐Mastercard ☐AMEX ☐ Discover | ☐ Other: _____

Card number: _____ Exp. date: __/____ Security code: _____

As a courtesy we will bill your in-network 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 y our insurer has not paid us within 60-days of submission of your bill, we will 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 deductibles, 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.

If you pay by check and that check is returned to us for any reason, you agree that the following will be charged to your card on file: your entire balance due and any returned check fees charged to us. If you do not provide a valid credit card, any unpaid balances will be sent to collections. Collection agencies may impose additional fees on your bill.

By signing below, the cardholder authorizes the above credit card to be charged for agreed purchases or services, including cancellation, or returned check charges, and to be saved to our file under this Credit Card Policy.

_____ _____ _____

Signature Print Name Date

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: _____

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— WELLNESS —

INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

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

I, the undersigned, 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*. Attach additional pages if necessary.

- Physical therapy intervention for diagnosis
- Internal pelvic muscle assessment.

Further, I, the undersigned, voluntarily authorize the Practice's disclosure and use of my protected health information contained in 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 another third-party payor, AND to the extent necessary to coordinate care with my primary care physician or another treating provider. I agree and acknowledge that: my insurance company, or another 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 the 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. I further agree that information regarding schedule changes, billing, health information may be disclosed to me by email, phone, and text message.

Further, I, the undersigned, acknowledge and agree 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; 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 the evaluation of my condition, it may be necessary for a Practice provider to perform an internal pelvic floor exam, both during the initial evaluation and throughout treatment.
- I may have a second person present in the exam room during treatment, but it is my responsibility to bring such a 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.
- 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; the Practice's policies bind me; I am bound to indemnify the Practice and voluntarily assume all risk.
- We may charge my credit card and keep it on file 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.

This document may be electronically signed. Electronic signatures on this document are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

_____ _____

Signature Date