Ingalls
Memorial Hospital
One Ingalls Drive, Harvey, Illinois 60426 (708) 333-2300

*P T 0 3 7 5*

**Patient Information Guidelines**
**Department of Outpatient Therapy Services**
Physical, Speech and Occupational Therapy

The staff at Ingalls Outpatient Therapy Services Department is dedicated to providing you with high quality rehabilitation services. In order for us to provide you with the best possible care and support in achieving your rehabilitation goals, it is important to maintain your course of treatment by keeping your appointments. Therefore, we ask that you comply with the following conditions:

- Appointments are scheduled on a weekly basis. It is your responsibility to pick up your schedule or call to obtain your schedule for the following week.
- Appointments may not be at the same time/day each week.
- It is your responsibility, as the patient, to contact the Therapy Services Department at least 24 hours in advance if you wish to cancel, change or reschedule an appointment.
- Ingalls will assess a $15 fee for the following reasons of cancellation:
  - Appointments that are cancelled less than 24 hours from the original scheduled appointment time.
  - Missed appointments.
  - Late arrivals that we are unable to accommodate.
- The $15 fee is your responsibility as the patient and will not be covered by insurance. You will be expected to pay at your next scheduled appointment.
- Ingalls' guideline is to discharge patients after the third instance that he or she misses a scheduled appointment that is not cancelled or rescheduled with at least a 24 hour notice.

Flossmoor: (708) 915-8465 Harvey: (708) 915-5024
Tinley Park: (708) 915-7460 ICOR: (708) 862-5500
Crestwood: (708) 915-2727

I have read the above guidelines and understand my responsibilities.

Patient Signature:_____ Date_____

Therapist Printed Name:_____

Therapist Signature with credentials:_____ Date_____

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**Patient Medical/Surgical History**
Department of Therapy Services
(Physical, Speech and Occupational Therapy)

*P T 0 3 7 6*

## MEDICAL/SURGICAL HISTORY

Please check if you have or ever had:
(Please check all that apply)

- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Broken Bones
- ☐ Cancer
  Type:_____
- ☐ Cardiac Problems
- ☐ Circulation Problem
- ☐ Depression
- ☐ Diabetes
- ☐ Growth Problems
- ☐ Head Injury
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
  Dialysis ☐ Yes ☐ No
- ☐ Lung Problems
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Repeated Infections
- ☐ Seizure/Epilepsy
- ☐ Skin Disease
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers/Stomach Problems
- ☐ Other:_____

Within the past year, have you had any of the following symptoms? (Please check all that apply)

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of Breath
- ☐ Dizziness or Blackouts
- ☐ Coordination Problems
- ☐ Weakness in Arms or Legs
- ☐ Loss of Balance
- ☐ Difficulty Walking
- ☐ Joint Pain/Swelling
- ☐ Pain at Night
- ☐ Gynecological/
  Obstetrical Difficulties
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Nausea/Vomiting
- ☐ Difficulty Swallowing
- ☐ Bowel Problems
- ☐ Weight Loss/Gain
- ☐ Urinary Problems
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Prostate Disease
- ☐ Pregnant
  (or think you may be)
- ☐ Other:_____

Do you smoke? ☐ Yes ☐ No
If yes, how many packs/day?_____
For how long?_____

HAVE YOU EVER HAD SURGERY? ☐ Yes ☐ No
If yes, please describe and include dates:
_____
_____
_____
_____

## CURRENT CONDITION(S)/ CHIEF COMPLAINT(S)

Describe the problem to which you seek therapy:
_____
_____
_____

When did the problem(s) begin? _____
Please describe what happened:
_____
_____
_____

Have you ever had the problem(s) before? ☐ Yes ☐ No
If yes, what did you do for the problem(s):
_____
_____
_____

Did the problem(s) get better? ☐ Yes ☐ No
How long did the problem(s) last? _____

What makes the problem(s) better?
_____
_____

What makes the problem(s) worse?
_____
_____

What are your goals for therapy?
_____
_____

MEDICATIONS (Type and Amount)
_____ _____
_____ _____
_____ _____
_____ _____

Have you taken any medications previously for the condition for which you are seeing the therapist? ☐ Yes ☐ No
If yes, please list:_____

Allergies:
_____
_____
_____

Patient Signature:_____ Date:_____

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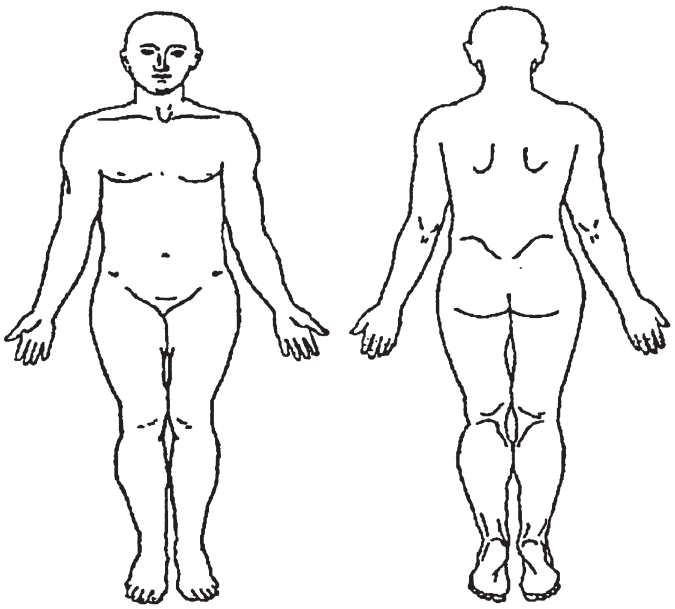
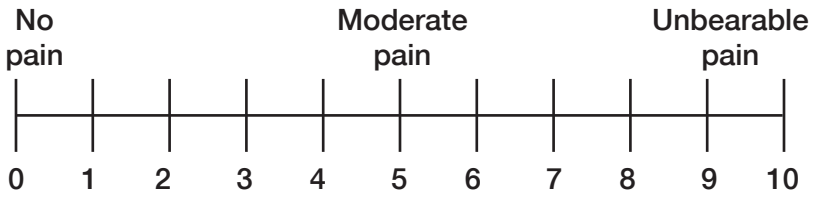
**Patient Medical/Surgical History**
**Pain Questionnaire**
Department of Therapy Services
(Physical, Speech and Occupational Therapy)

*PT0377*

1. Please mark on the drawing below the areas which you feel pain for this condition.



2. How intense is your pain? Please circle a number on the scale.




3. Please describe your pain. Check any words that apply.

☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing
☐ Ache ☐ Nagging ☐ Constant ☐ Intermittent
☐ Shooting ☐ Other:_____

Patient Signature:_____ Date:_____

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*C O 0 0 0 1*

# LEGAL NOTICE TO PATIENTS
# PHYSICIANS ARE NOT EMPLOYEES OR AGENTS OF HOSPITAL

**Please read carefully.**

The law in Illinois requires Ingalls Memorial Hospital ("Ingalls") to tell you that:

- Your physicians, including but not limited to, your personal/attending physician, emergency room and urgent aid physicians, radiologists, pathologists, anesthesiologists, on-call physicians, consulting physicians, surgeons, obstetricians/gynecologists, and allied health care providers working with those physicians, are not employees or agents of Ingalls.

- Your physicians and the allied health care professionals working with those physicians are independent medical practitioners who have been permitted to use Ingalls for the care and treatment of their patients. As independent medical practitioners, they exercise their own professional judgment in caring for their patients and they are not supervised or controlled by Ingalls.

- Your physicians will bill you separately from Ingalls for their services.

- You have the right to choose your own physicians and the right to change any of your physicians at any time.

I have read and understand all of this form. I understand all of the information being provided to me in this document. I understand and agree that the physicians and the allied health care professionals working with those physicians are not employees or agents of Ingalls. By accepting this form, I am saying that I understand and agree to what it says.

Patient _____ Date _____

Witness _____

Signature of Interpreter _____ Language _____ Date _____

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- Harvey
- Calumet City
- Tinley Park
- Matteson
- Wellness Center
- Flossmoor

## CONSENT FOR TREATMENT

1. I understand that my condition requires hospital care and I voluntarily consent to such hospital care, which may occur on different dates in the case of preadmission testing, including laboratory tests, diagnostic procedures, and medical treatment as deemed necessary in the judgment of my physician and such associates and assistants as may be selected by this physician, or by physicians affiliated with Midwest Emergency Associates, or Sullivan Urgent Aid Centers, independent physicians who practice in the Ingalls Emergency Department and Urgent Aid. I understand that physicians, nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to such student involvement in my care.

2. I have been informed and understand that physicans providing services to me at Ingalls, including, but not limited to, my personal physician, Emergency Department and Urgent Aid physicians, radiologists, pathologists, anesthesiologists, on-call physicians, consulting physicians, surgeons and allied health care providers working with those physicians are not employees, agents or apparent agents of Ingalls, but are independent medical practitioners who have been permitted to use Ingalls' facilities for the care and treatment of their patients. I further understand that each physician will bill me separately for their services and may not be participating providers in the same insurance plans and networks as the hospital, which could cause a greater out of pocket financial responsibility.

3. I understand I have the right to select my own physicians and the right to change physicians at any time during my hospitalization, including, but not limited to, my personal physician, emergency department physicians, urgent aid physicians, radiologists, pathologists, anesthesiologists, on-call physicians, consulting physicians, surgeons and any allied health care providers working with those physicians.

4. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any diagnosis, treatment, surgery, test or examinations conducted or performed.

5. I understand that I am assuming full responsibility for all of my personal property, including dentures, eyeglasses, prosthetics, and other valuables which may be kept by me during my hospital stay.

6. I assign my rights to any insurance benefits to which I may be entitled directly to Ingalls, Midwest Emergency Associates, Sullivan Urgent Aid Centers, and any other medical provider who may provide medical/surgical treatment.

7. I understand that my medical records are protected under federal and state law and may be disclosed without my written consent for the purposes of treatment, payment and healthcare operations. I further understand that the specific type of information to be disclosed may include diagnosis, prognosis, treatment for physical or psychiatric illness, treatment for alcohol or substance abuse, or HIV testing.

8. I understand that I will be financially responsible for any charges incurred for my examination and treatment if I refuse to allow disclosure of my medical records for billing and such refusal results in denial of payment by my insurance.

9. The Ingalls Health System Joint Notice of Privacy Practices has been made available to me.

10. If I am an inpatient Medicare beneficiary I acknowledge that I have been given a copy of the "Important Message from Medicare" patient letter.

*C O 0 0 0 1*

This consent may be revoked in writing by me at any time, except to the extent that actions have been taken in reliance on the consent given.

Printed Name of Patient _____ Signature _____

Street Address _____ City _____ State _____ Zip Code _____

Date _____ Witness _____

(IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING)

Patient named is a minor, _____ years of age.

Patient named above is unable to sign because:_____

_____

_____

Signature of Person Authorized to Consent for Patient _____ Date _____

Relationship _____

Street Address _____ City _____

State _____ Zip Code _____ Telephone _____

Witness _____

Signature of Interpreter _____ Language _____ Date _____

**HOSPITAL USE ONLY**
**CONSENT NOTES (Document attempts to obtain signature and/or reason signature has not been obtained.)**

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*H C 0 0 0 1*

# HOME CARE QUESTIONNAIRE

## Are you currently receiving any Home Care services, including nursing, speech therapy, physical therapy or occupational therapy?

## YES NO

## If you answered Yes, please notify the front desk and your Therapist. Outpatient Therapy is NOT covered while receiving home care services and you will be responsible for payment prior to your visit.

Patient Signature:_____ Date_____

Printed Name_____

Legally Authorized Representative:_____ Date_____

Printed Name_____

Form # 2708 (04/14)