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____________________
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

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: ______________________
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.

<table>
<thead>
<tr>
<th>No pain</th>
<th>Moderate pain</th>
<th>Unbearable pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

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

   - □ Sharp
   - □ Dull
   - □ Burning
   - □ Throbbing
   - □ Ache
   - □ Nagging
   - □ Constant
   - □ Intermittent
   - □ Shooting
   - □ Other: ______________________________

Patient Signature:___________________________________________________________ Date:______________________
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

Form # 2487 (03/13)
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 physicians 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 hospi-
talization, 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.
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.

<table>
<thead>
<tr>
<th>Printed Name of Patient</th>
<th>Signature</th>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Witness</th>
</tr>
</thead>
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(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:_______________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Signature of Person Authorized to Consent for Patient</th>
<th>Date</th>
</tr>
</thead>
</table>

Relationship

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Zip Code</th>
<th>Telephone</th>
</tr>
</thead>
</table>

Witness

<table>
<thead>
<tr>
<th>Signature of Interpreter</th>
<th>Language</th>
<th>Date</th>
</tr>
</thead>
</table>

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