

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

PHYSICAL THERAPY

PERSONAL TRAINING

Dear New Patient:

On behalf of your Physical Therapists of Total Rehab, P.C. and all of the staff at Just Be Fit, Inc. we would like to welcome you to our facility. As you probably have noticed, we have teamed up with Total Rehab, P.C. to enhance the services offered. Total Rehab, P.C. is committed to being an affordable provider of physical therapy services. To accomplish this goal, their fees for professional services are either the same as, or in many cases less than, area hospitals or other outpatient facilities. In addition, they accept insurance assignment in all cases.

Our Physical therapists understand what it's like to be injured, and that time is an issue—both finding the time to complete a therapy program and the time it takes to heal an injury. They use contemporary techniques to efficiently and effectively return you to your life. We recognize your pain is unique, and your treatment plan will be too.

Our expert approach to physical therapy involves:

- **Personalized Care**
- **Constant Communication**
- **Fully Comprehensive Treatment**
- **Detailed Evaluations**

Once Physical Therapy is complete, we offer a specialized continuation program for any age individual with re-occurring pain or injuries. This will provide a comprehensive approach for you to improve or maintain the gains made in physical therapy or other rehabilitation experiences. Our approach emphasizes the concept of functional exercise to help individuals improve their level of function, strength, flexibility, endurance or balance. Our expert staff of Registered Kinesiotherapists helps make the transition from therapy to Exercise Based Rehabilitation painless.

Our expert approach to Exercised Based Rehabilitation involves:

- **Hands on approach to restoring mobility, stability and function based upon your specific injury.**
- **Joint mobilization techniques to increase range of motion.**
- **Through hands-on soft tissue therapy to decrease pain and address neurological symptoms.**
- **Defining proper movement patterns and addressing proper postural alignment.**

Our expert staff routinely treats the following conditions:

- **Neck:** Cervical Herniated disc, Arthritis, Mechanical Neck Pain
- **Back:** Stenosis Sprains/Strains, Sciatica, Herniated Discs, Arthritis
- **Hip:** Bursitis, Piriformis Syndrome, Sacroiliac Joint Dysfunction
- **Knee:** Arthritis, Iliotibial Band Syndrome, Knee Bursitis, Ligament Sprains, Meniscal Injuries, Tendonitis
- **Lower Leg / Ankle / Foot:** Gait Disorders, Achille's Tendonosis, Ankle Sprains, Plantar Fasciitis, Shin Splints

•• Outpatient Stroke Rehab

For patients who suffer from problems with:

- Weakness
- Balance
- Posture
- Walking
- Coordination
- Drop Foot Syndrome

We have provided professional rehabilitation services at this location since 1999. If you have any questions or concerns please feel free to contact our office at 847-444-1348.

Please feel free to visit our web site at www.justbefitinc.com

Once again thank you for choosing Just Be Fit, Inc. and / or Total Rehab, P.C.

TOTAL REHAB, P.C. PHYSICAL THERAPY

Name (Last): _____ (First) _____ (Middle) _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone : (____) _____ Evening Phone: (____) _____ Cell Phone : (____) _____

Social Security #: _____ Date of Birth: ____/____/____ Male Female

Primary Care Physician: _____ Phone: (____) _____

Insurance Information

Type of Coverage for Treatment: **PPO 1 HMO 1 MEDICARE 1 W/C 1 MVA 1 PI 1** Date of Injury ____/____/____

Medicare Patients Only: I am under the care of a home health agency: Yes No

If yes: From : ____/____/____ to : ____/____/____ Primary Care Physician last seen: ____/____/____

Primary Carrier: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Policy Holder: _____ Date of Birth : ____/____/____ Relationship _____

Address (if different) _____ City: _____ State: _____ Zip: _____

Policy Holder's Employer: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Carrier: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Policy Holder: _____ Date of Birth : ____/____/____ Relationship _____

Address (if different) _____ City: _____ State: _____ Zip: _____

Policy Holder's Employer: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

W/C or Liable Party's Carrier _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Contact person: _____ Claim # _____

Attorney or Firm Name (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Person: _____

Phone: (____) _____

Authorization and Assignment

I hereby authorize my insurance carrier to make benefit payments directly to Total Rehab, P. C., on my behalf. I hereby acknowledge my financial responsibility for fees not paid by this assignment and agree to pay for any collection and/or legal fees incurred if my account becomes delinquent.

Signature _____ Date: _____

Total Rehab, P.C.
Authorization to Disclose Health Information

Patient Name _____ Health Record Number _____
Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

The following individual or organization is authorized to make the disclosure:

Total Rehab, PC
100 E. Irving Park Road – Suite 107
Roselle, IL 60172

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

Evaluation(s)

Progress Notes

Most recent history and physical

Most recent discharge summary

Entire Record

Other _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization: _____

Address _____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Healthcare Management office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Greg Gale, Corporate Compliance Officer, at 630.439.0009.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness

Date

Total Rehab, P.C.

Acknowledgement of receipt of NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name

_____/_____/_____
Signature of Patient

Witness

Date ____/____/____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below

Date:	Initials:	Reason:
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Total Rehab, P.C.

Corporate Office

100 E. Irving Park Road, Suite 107

Roselle, Illinois 60172

Phone: 630.439.0009

fax: 630.439.0011

CANCELLATION/ MISSED APPOINTMENT POLICY

Dear Patient:

Please be aware that if you need to cancel your physical therapy appointment we would appreciate as much advance notice as possible; therefore call no later than 24 HOURS prior to your scheduled appointment date and time. There will be a fee of **\$25.00** billed to you personally, if you do not provide at least **24-hours notice of a cancellation**. Also, if you miss **THREE** consecutive scheduled physical therapy appointments without calling to cancel or reschedule your appointment you will be discharged immediately from physical therapy. This policy will be enforced after your initial physical therapy appointment.

We appreciate your courtesy and thank you for your cooperation. Total Rehab, P.C. looks forward to providing our physical therapy services to you.

Sincerely,

Total Rehab, P.C. Management

By signing below, I agree to pay the fees outlined in this policy.

Patient or Legal Representative Signature

Date

Total Rehab, P.C. Staff Signature

Date

Total Rehab, P.C.

Informed Consent for Treatment

By my signature, which appears below, I hereby grant my permission for and request that I be evaluated and treated by the physical and/or occupational therapist(s) according to the plan of care developed by the physical and/or occupational therapist and prescribe by my physician in consultation with the therapist(s).

I understand that the purpose of this program is to enhance my recovery from an illness, injury or surgery. It have been explained to me that there exists the likelihood of changes in the treatment program as my condition changes and I hereby grant my permission for all modifications and changes to the treatment program deemed necessary by the therapist(s).

The procedures and or modalities to be used have been explained to me and I have had the opportunity to ask any questions I had, and acknowledge that I have received answers that are satisfactory to me. I understand that the success of this or any other medical treatment program depends on my involvement and cooperation with the program including regular attendance at all treatment sessions and conscientious follow through with any home exercise or procedures which may be prescribed by the therapist(s). I understand what is expected of me as patient and agree to cooperate to the best of my ability.

I hereby attest that I have read and agreed to all statements made above and that my participation in this physical and/or occupational therapy treatment program is fully voluntary.

_____/_____/_____
Signature of Patient

Date

_____/_____/_____
Witness

Date

Notice of Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.525
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our responsibilities

This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Corporate Compliance Officer at 630.439.0009.

If you believe your privacy rights have been violated, you can file a complaint with the Corporate Compliance Officer or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by your physical therapist will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of your physical therapist. Your therapist will then record the actions he/she took and their observations. In that way the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from therapy.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the corporate compliance officer, or other members of our physical therapy staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates:

There are some services provided in our organization through contacts with business associates. Examples include our billing service. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with family:

Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment relates to your care.

Research:

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing:

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers Compensation:

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Effective Date: