# CONSENT FOR MEDICAL TREATMENT

**CONSENT FOR DIAGNOSIS AND TREATMENT:** This is to certify that I, the undersigned, hereby authorize and consent to the giving of all treatments, examinations, medications, and any technical procedures which in the judgment of my physician and the medical and/or surgical staff of Franciscan St. James Health may be considered necessary or advisable for the diagnosis or treatment of my case. 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 regarding the results of any diagnosis, treatment, surgery, test or examinations conducted or performed at Franciscan St. James Health. I further understand that Franciscan St. James Health is a teaching facility and as such there are physicians who hold limited licenses to practice medicine and are currently in residency programs and as such may be asked to attend me from time to time during my stay within the scope and limitation of the residency program.

**AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize Franciscan St. James Health and any physician or other health care provider who may treat me to release any and all pertinent information contained in my medical records to other hospitals, clinics, doctors, nurses and healthcare providers who request them for the purpose of my medical diagnosis and care, or to those organizations which pay or manage my medical care. In the event of ambulance transport, medical diagnosis, medical history and treatment information will be released to the ambulance transport service for billing purposes. This release may occur during the hospitalization and/or any time after discharge and will not expire until all claims for this hospitalization are resolved. I understand that this authorization may include information regarding medical, mental health, developmental disabilities, drug or alcohol abuse, or HIV and related diseases. This consent may be revoked at any time by written notice to the Medical Record Department (with no effect on prior disclosures).

**PERSONAL VALUABLES:** I acknowledge that I have been advised against keeping valuables on my person or in my room and that a hospital safe is available for storage of my valuables. I acknowledge and agree that the hospital is not responsible for any personal property, including valuables, which I choose to retain in my possession, or which are not deposited in the hospital's safe in accord with hospital policy.

**PHOTOGRAPHS:** I understand photos may be taken during the course of my treatment in connection of treatment I may receive. I consent to those photos and for them to be part of my Medical Records.

**STATEMENT OF UNDERSTANDING: PHYSICIANS ARE NOT EMPLOYEES OF THE HOSPITAL:** Franciscan St. James Health is committed to providing its patients with complete information about the care received and believes it is important for you to understand the relationship between the physicians providing that care in the hospital. **With the specific exception of certain primary care doctors who are with the medical group of Franciscan Physician Network and are so identified, the physicians who treat you at Franciscan St. James Health are not employees or agents of the hospital. They are independent physicians who, as part of their private practice, see and treat patients of the hospital.** These physicians include your private physician or physician from a group who has agreed to treat you if you do not have a physician on-staff at the hospital, as well as doctors that may consult on your care including, but not limited to, radiologists, pathologists, cardiologists, anesthesiologists, surgeons, emergency room physicians, and all other specialists. (_____) Initial.

**I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS CONSENT AND THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS OR OTHER ASPECT OF ANY TREATMENT, PROCEDURE, OR TEST AUTHORIZED HEREUNDER.**

**Patient** _____ **Date and Time** _____

**Or-Patient's Representative** _____ **Date and Time** _____

**Relationship to Patient**_____ **Reason Patient Cannot sign** _____

**Witness** _____ **Date and Time** _____

I the undersigned acknowledge that I understand and have been advised that attending physicians and other doctors who provide treatment to me at Franciscan St. James Health are not employees or agents of the hospital except as described in the **STATEMENT OF UNDERSTANDING: PHYSICIANS ARE NOT EMPLOYEES OF THE HOSPITAL**, but rather independent physicians with their own private practices. I have had an opportunity to ask and have received answers to any and all questions I have about the relationship of the physicians and the hospital. I acknowledge that the employment or agency status of physicians who treat me are not in any way a reason for nor otherwise relevant to my selection of Franciscan St. James Health for care.

**Patient or Authorized Representative:** _____ **Date and Time** _____

**Admissions Representative:**_____ **Date and Time:**_____

Franciscan
ST. JAMES HEALTH

***A photostatic copy of this form will be considered a valid authorization.***

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX

**CONSENT FOR MEDICAL TREATMENT**

# AUTHORIZATION FOR PAYMENT/RELEASE OF RESPONSIBILITY

## AUTHORIZATION FOR DISCLOSURE OF INFORMATION

**I certify that information given to me in applying for payment under a Federal, State, Commercial or other Insurance Plan is correct. I hereby authorize any holder of medical or other information about me to release to the applicable insurance carrier or administering entity any information needed for this or any related claim. I request that payment of authorized benefits be made on my behalf.**

## AUTHORIZATION FOR RELEASE OF INFORMATION

**I hereby authorize Franciscan St. James Health and any physician or other health care provider who may treat me to release any and all pertinent information contained in my medical records to other hospitals, clinics, doctors, nurses and healthcare providers who request them for the purpose of my medical diagnosis and care, or to those organizations which pay or manage my medical care. In the event of ambulance transport, medical diagnosis, medical history and treatment information will be released to the ambulance transport service for billing purposes. This release may occur during the hospitalization and/or any time after discharge and will not expire until all claims for this hospitalization are resolved. I understand that this authorization may include information regarding medical, mental health, developmental disabilities, drug or alcohol abuse, or HIV and related diseases. This consent may be revoked at any time by written notice to the Medical Record Department (with no effect on prior disclosures).**

## PAYMENT FOR SERVICES

**I agree, whether I sign as patient or as agent, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the hospital in accordance with the regular rate and terms of the hospital. Should the account be referred to collection I agree to pay any collection expense including attorney's fees.**

## PATIENT PRE-CERTIFICATION RESPONSIBILITY

**I understand that my insurance plan may require pre-certification to authorize this hospitalization. I further understand that if I do not meet my responsibility to obtain pre-certification that I may incur a reduction or loss of paid benefits to the hospital for which I will be financially responsible for.**

## ASSIGNMENT OF BENEFITS

**I hereby authorize payment directly to Franciscan St. James Health of all the hospital insurance benefits payable. I understand that I am financially responsible to the hospital for charges not covered by this assignment.**

## TELEPHONE / CELL PHONE NUMBER

**In order to contact me related to my healthcare and financial arrangements, I authorize Franciscan Alliance, Inc. and its designees to utilize any and all of my contact information (including my email and cell phone) provided to Franciscan Alliance, Inc., or any of its divisions, and utilizing various methods including automated calling, texting and the use of pre-recorded messages.**

## RELEASE OF RESPONSIBILITY FOR VALUABLES

**I also understand that I am fully responsible for all articles (money, hearing aids, jewelry, dentures, eye glasses, etc.) and clothing which I retain in my possession (in my room) and for any other articles and/or clothing which may be brought to me while I am a patient at Franciscan St. James Health. The hospital and employees are not responsible for loss of, or damage to, property which is not specially deposited for safe keeping in the Franciscan St. James Health's vault.**

## STATEMENT OF UNDERSTANDING: PHYSICIANS ARE NOT EMPLOYEES OF THE HOSPITAL

**Franciscan St. James Health is committed to providing its patients with complete information about the care received and believes it is important for you to understand the relationship between the physicians providing that care in the hospital. With the specific exception of certain primary care doctors who are with the medical group of Franciscan Physician Network and are so identified, the physicians who treat you at Franciscan St. James Health are not employees or agents of the hospital. They are independent physicians who, as part of their private practice, see and treat patients of the hospital. These physicians include your private physician or physician from a group who has agreed to treat you if you do not have a physician on-staff at the hospital, as well as doctors that may consult on your care including, but not limited to, radiologists, pathologists, cardiologists, anesthesiologists, surgeons, emergency room physicians, and all other specialists. You acknowledge that the employment or agency status of physicians who treat you are not in any way a reason for nor otherwise relevant to your selection of Franciscan St. James Health for your care. You understand that in most cases you will receive separate bills for services provided by health care professionals affiliated with the hospital. Some of these individuals may not participate in the same insurance plans as the hospital. You may have greater out-of-pocket costs for services provided by out-of-network providers. You should contact your health care plan for questions concerning coverage or benefit levels and for subscriber's certificate of coverage. (_____) Initial**

**I HAVE READ ALL OF THE ABOVE AND CERTIFY THAT I UNDERSTAND ALL SECTIONS**

**Patient**_____ **Date and Time** _____

**Or-Patient's Representative**_____ **Witness** _____

**Relationship to Patient**_____ **Reason Patient Cannot sign** _____

**A photostatic copy of this form will be considered a valid authorization.**

Franciscan
ST. JAMES HEALTH

**AUTHORIZATION FOR PAYMENT/ RELEASE OF RESPONSIBILITY**

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX

Effective Date: September 23, 2013

Franciscan ALLIANCE

## NOTICE OF PRIVACY PRACTICES

### Acknowledgement Form

**By signing below, I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices ("Notices"). I understand that I may obtain a written copy of this Notice at any time upon request or via the website at franciscanalliance.org**

| | |
|---|---|
| Name of Patient | Date of birth |
| Patient or Legal Guardian Signature | Date |
| Witness Signature | Date |

Reason Given by Patient if Refusing to Sign this Notice

Recorder's Signature

Scan to: HIPAA Notice of Privacy Practice

**HIPAA**

**NOTICE OF PRIVACY PRACTICE**

Patient Label

Franciscan HEALTH

Milestone THERAPY

## CHILD CASE HISTORY FORM

| | | |
|---|---|---|
| Child's Name: | | DOB: |
| Address: | | Phone: |
| City: | State: | Zip: |

Does the child live with both parents? _____

| | |
|---|---|
| Mother's Name: | DOB: |
| Phone: | Email: |

| | |
|---|---|
| Father's Name: | DOB: |
| Phone: | Email: |

| | |
|---|---|
| Pediatrician's Name: | Phone: |
| Address: | Fax: |
| Diagnosis: | |

| | |
|---|---|
| Specialist Name &Office 1: | Phone: |
| Address: | Specialist Type: |
| Specialist Name & Office 2: | Phone: |
| Address: | Specialist Type: |
| Specialist Name & Office 3: | Phone: |
| Address: | Specialist Type: |

**What is the child's primary language?** _____

**With whom does the child spend most of their time?** _____

**Describe the concerns you have regarding your child.** _____

_____

**How does your child usually communicate (gestures, single words, short phrases, sentences)?**

_____

_____

**Please give two or three examples of commonly used comments your child uses.** _____

_____

_____

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CHILD CASE HISTORY FORM

PLACE LABEL
WITHIN THE BOX

When was the concern first noticed? _____

_____

Has the problem changed since it was first noticed? _____

_____

Is your child aware of the concern? _____ If yes, what are their feelings on the subject _____

_____

Have any other specialists seen the child? _____

Who? _____

When? _____

What were the conclusions or suggestions? _____

_____

Who? _____

When? _____

What were the conclusions or suggestions? _____

_____

**PARENTAL & BIRTH HISTORY**

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)

_____

_____

_____

Length of pregnancy: _____ Length of labor: _____ Birth weight: _____

General condition: _____

Circle type of delivery: head first feet first breech cesarean

Were there any unusual conditions that may have affected the pregnancy or birth? _____

_____



PLACE LABEL
WITHIN THE BOX

## CHILD CASE HISTORY FORM

**Did your child experience any early feeding/swallowing problems (weak suck, turning "blue" while attempting to nurse, projectile vomiting, choking, lack of appetite, early fatigue, milk coming out of nose while nursing, etc.)?** _____

_____

**Medical History**

**Does your child have a history with:**

| Item | Yes | No | Explanation |
|---|---|---|---|
| Speech Problems | | | |
| Hearing Problems | | | |
| Learning Disabilities | | | |
| Seizures/Convulsions | | | |
| Intellectual Disabilities | | | |
| Autism/Spectrum Disorder | | | |
| Hearing Problems | | | |
| Ear Infections | | | |
| PE Tubes | | | |
| Frequent Colds/Sinus Infections | | | |
| Bronchitis / Pneumonia | | | |
| Drainage from Ear | | | |
| Tonsils/Adenoids Removed | | | |

**Has your child experienced any of the following?**

| Item | Yes | No | Explanation |
|---|---|---|---|
| Visual Difficulties | | | |
| High Fevers lasting longer than 1 day | | | |
| Tuberculosis | | | |
| Asthma | | | |
| Hospitalization | | | |
| Surgery | | | |
| Encephalitis | | | |
| Head Injury | | | |
| Swallowing/Chewing Problems | | | |
| Other | | | |

## CHILD CASE HISTORY FORM

**Further Explanation:**

_____

_____

_____

**Describe any major accidents or hospitalizations?** _____

_____

**Does your child take any medications?** _____

_____

**Does your child have any known allergies?** _____

_____

**Developmental History**

| Item | Yes | No | Explanation |
|---|---|---|---|
| Hold his/her head up by 4 months | | | |
| First crawl by 12 months | | | |
| First walk alone by 16 months | | | |
| Was toilet-trained by 3 years | | | |
| First grasped crayon/pencil with thumb & finger by 3 years | | | |
| First sit alone by 12 months | | | |
| First ate solid food by 12 months | | | |
| Fed self by 2 years | | | |
| First use scissors by 3 years | | | |
| Did child cry normally (communicate pain, fear, discomfort, loneliness | | | |
| Cooing / babbling by age 4 months | | | |
| Respond to name / peek-a-boo by 8 months | | | |
| Using jargon by 12 months | | | |
| Imitate sounds by 12 months | | | |
| Saying his first word by 15 months | | | |
| Saying 2 words together by 24 months | | | |
| Using short sentences by 36 months | | | |

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CHILD CASE HISTORY FORM

PLACE LABEL
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Franciscan HEALTH

Milestone THERAPY

## CHILD CASE HISTORY FORM

**Please describe your child's gross motor skills (coordinated, clumsy, falls a lot, slow, etc.) while walking, running, climbing, riding bikes, roller skating, etc.**

_____

_____

_____

**Please describe your child's response to sound (e.g. responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.)**

_____

_____

_____

**Please describe your child's fine motor skills while attempting to color, write, draw, cut with scissors, feed him/herself with utensils, etc.**

_____

_____

_____

**Has your child's hearing been tested previously? When & what were the results?**

_____

_____

**Indicate with a checkmark any items that are difficult for your child:**

| | | | | |
|---|---|---|---|---|
| ☐ | Eating a variety of foods | | ☐ | Pronouncing words correctly |
| ☐ | Following directions or routines | | ☐ | Stating sounds of letters |
| ☐ | Answering questions | | ☐ | Recognizing "common" words |
| ☐ | Singing songs / reciting nursery rhymes | | ☐ | Rhyming |
| ☐ | Understanding what he/she hears | | ☐ | Thinking of words for things |
| ☐ | Speaking in organized sentences | | ☐ | Telling stories |
| ☐ | Speaking in grammatically correct sentences | | ☐ | Receiving or giving hugs |
| ☐ | Eye-Hand coordination | | ☐ | Understanding the concept of time (seasons, day/night, hours) |
| ☐ | Blowing bubbles | | ☐ | Ability to self-calm |
| ☐ | Writing his/her name | | ☐ | Keeping shoes on |
| ☐ | Getting his/her point across | | ☐ | Using a straw |
| ☐ | Keeping hands to him/herself | | ☐ | (Other) |

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CHILD CASE HISTORY FORM

PLACE LABEL

WITHIN THE BOX

## CHILD CASE HISTORY FORM

**Behavioral History:**

| | | | | |
|---|---|---|---|---|
| ☐ | Friendly | | ☐ | Separation difficulties |
| ☐ | Easy going | | ☐ | Poor eye contact |
| ☐ | Plays well with other children | | ☐ | Cooperative |
| ☐ | Aggressive / destructive | | ☐ | Attentive |
| ☐ | Has temper tantrums | | ☐ | Willing to try new activities |
| ☐ | Unpredictable | | ☐ | Will not eat certain textures |
| ☐ | Sleeps well | | ☐ | Will not touch certain textures |
| ☐ | Eats well | | ☐ | Overly sensitive emotionally |
| ☐ | Plays alone for reasonable amount of time | | ☐ | Still uses pacifier / sucks thumb |
| ☐ | Doesn't like to be touched | | ☐ | Has nightmares |
| ☐ | Talkative | | ☐ | Grinds teeth |
| ☐ | Clumsy | | ☐ | Distractible / short attention span |
| ☐ | Impulsive / impatient | | ☐ | Easily frustrated |
| ☐ | Difficulty sleeping | | ☐ | Restless |
| ☐ | Hyperactive | | ☐ | Quiet |
| ☐ | Doesn't like to be read to | | ☐ | Wets bed |
| ☐ | Poor memory | | ☐ | Withdrawn |
| ☐ | Defiant | | ☐ | Shy |
| ☐ | Cannot easily shift from one activity to another | | ☐ | Daydreams often |
| ☐ | Bites nails | | ☐ | Mouth breather |
| ☐ | Stubborn | | ☐ | Snores |
| ☐ | Bad tempered | | ☐ | Sensitive to sounds |
| ☐ | Cries easily | | ☐ | (Other) |

**Educational History**

School _____

Grade_____Teacher_____

**How is your child doing academically (or pre-academically)?**

_____

_____

Franciscan HEALTH

Milestone THERAPY

## CHILD CASE HISTORY FORM

**How does your child interact with others (shy, aggressive, uncooperative, etc.)?**

_____

_____

**IF enrolled for special services or services in school, has an Individualized Educational Plan (IEP) been developed? IF yes, describe the most important goals.**

_____

_____

_____

**Person completing form:**_____ **Date:**_____

**Relationship to child:**_____

**Signature:**_____

# Outpatient Therapy Orientation v3.0

## METT THERAPY POLICIES FOR TREATMENT AND SCHEDULING

- Patients are responsible to know their insurance benefits. Each provider has differences in coverage.
- Verify your insurance coverage includes **FRANCISCAN St. James Health** as a service provider.
- Please notify the front desk staff of any changes to your insurance. This should be checked each month to ensure proper coverage.
- **NO CELLULAR PHONE USE IS ALLOWED IN OUR FACILITY – PLEASE TURN THEM OFF**
- Proper attire is required for therapy treatment. You will need to be able to expose the area of injury for treatment.
- Proper footwear is required for therapy treatment. **No high heels.**
- **Patients only** will be allowed in the treatment area. **Guests** will wait in the lobby during the time of treatment.
- Appointment times are important to effectively treat your condition by our therapy staff. Please arrive 15 mins. before your appointment time to ensure a full treatment can be provided.
- Please sign-in for each visit you attend.
- Please check-in with the front desk if you arrive late or very early for your visit, so they can notify the therapist.
- Appointment scheduling at the front desk is the responsibility of the patient. Appointments can be scheduled after the time of the initial evaluation and a plan of care is established with the treating therapist.
- We require **24-HOUR NOTICE** for any cancellation of an appointment. A fee will be charged for failure to comply. $50.00 for an evaluation. $25.00 for a missed appointment.
- If you must cancel appointments, please attempt to reschedule the appointment the same week or add a visit to the following week to make up the missed appointment.
- Attendance is needed to effectively treat your condition. **3 cancellations, no shows or any combination within 30 days will result in termination of your therapy program.** Your appointments will be cancelled and you must return to your physician to restart your therapy.
- Worker's compensation patients, who fail to comply with the physician's recommended appointments, will have their governing parties notified for each appointment cancelled or not attended.
- Please inform your therapist of all return visits to your physician.
- My signature below indicates my willingness to comply with these policies and procedures.

I have read and agree to comply with the above policies and procedures of FRANCISCAN St. James Health.

| **Patient signature** | **Date** |
|---|---|

I have read and agree to comply with and my child will comply with the above policies and procedures of FRANCISCAN St. James Health.

| *Guardian signature* ***FOR PATIENTS UNDER THE AGE OF 18*** | *Date* |
|---|---|

Franciscan
ST. JAMES HEALTH

OUTPATIENT REHABILITATION SERVICES
THERAPY ORIENTATION

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX


1INTDSP

# Patient Intake Data Sheet v3.0

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient's last name: | First: | Middle: | ❑ Married ❑ Widowed<br>❑ Single ❑ Divorced | Date of Birth:<br>SS#: |
| Mother's maiden name: | Referring Physician: | | Primary Care Physician: | |
| Patient's Street address: | | | Patient's Home phone no.:<br>( ) | Patient's Cellular phone no.:<br>( ) |
| City: | State: | ZIP code: | Email address: | |
| Sex (Legal): ❑ M ❑ F | Gender Identity: ❑ Male ❑ Female ❑ Transgendered ❑ Other: | | | |

## IN CASE OF EMERGENCY

| | | |
|---|---|---|
| Name of emergency contact person: | Relationship to patient: | Phone no.:<br>( ) |

## EMPLOYMENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Employer's name: | | | Employer's address: | | |
| Job Title: | ❑ Part time<br>❑ Full time | Work phone no.:<br>( ) | City: | State: | ZIP code: |

## INFORMATION OF POLICY HOLDER

❑ Check here if information is the same as the patient above.

| | | | | |
|---|---|---|---|---|
| Policy holders last name: | First: | Middle: | Relationship to patient | Date of Birth:<br>SS#: |
| Policy holders employer's name: | | | Employer's address: | |
| Job Title: | ❑ Part time<br>❑ Full time | Work phone no.:<br>( ) | City: | State: ZIP code: |

## PRIMARY INSURANCE INFORMATION

Insurance Type: ❑ HMO ❑ PPO ❑ Medicare ❑ Public Aide ❑ Workman's Comp. ❑ Other (specify)_____

| | | | |
|---|---|---|---|
| Insurance ID #:<br>Insurance Group #: | Insurance address: | | |
| Phone no.:<br>( ) | City: | State: | ZIP code: |

## SECONDARY INSURANCE INFORMATION

Insurance Type: ❑ HMO ❑ PPO ❑ Medicare ❑ Public Aid ❑ Workman's Comp. ❑ Other (specify)_____

| | | | |
|---|---|---|---|
| Insurance ID #:<br>Insurance Group #: | Insurance address: | | |
| Phone no.:<br>( ) | City: | State: | City: |

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**OUTPATIENT REHABILITATION SERVICES**
**INTAKE DATA SHEET**

35 998586 Rev. 10/11, 8/17, 11/17



**PATIENT LABEL MUST BE PLACED WITHIN THIS BOX**

Registration Form

## ACCIDENT/INJURY/WORKMANS COMPENSATION INFORMATION V3.0

| | |
|---|---|
| Date of accident: | Accident type: |
| How accident occurred: | |
| | |
| Where accident occurred: | |
| State accident occurred in ( circle one): IL IN WI MI Other (specify) _____ | |

## INSURANCE COMPANY RESPONSIBLE FOR PAYMENT

| | | | | |
|---|---|---|---|---|
| Company name: | | Claim number: | | |
| Contact person: | | Company's address: | | |
| Phone no.:<br>( ) | Fax no.:<br>( ) | City: | State: | ZIP code: |

## ATTORNEY INFORMATION

| | | | | |
|---|---|---|---|---|
| Attorney or company name: | | Employer's address: | | |
| Phone no.:<br>( ) | Fax no.:<br>( ) | City: | State: | ZIP code: |

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ST. JAMES HEALTH

**OUTPATIENT REHABILITATION SERVICES**
**INTAKE DATA SHEET**

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX