



5359 Balboa Blvd.
Encino, CA 91316
tel: 310-860-6110
fax: 310-861-1462
www.neuwellness.com

NEU-WELLNESS INSTITUTE CHANGE OF SCHEDULE / REFUND POLICY

Thank you for choosing Neu-Wellness Institute to provide an excellent rehabilitation program. We recognize that from time to time situations arise and plans need to be changed due to situations beyond your control. Below you will find our policies for deposits, payments and cancellations.

Should you need to cancel your reserved spot after a deposit has been received, and prior to 45 days before a scheduled session, the deposit will be credited to your account for one calendar year for any available session without penalty. Neu-Wellness Institute strives to work with families in any way possible, and our mission is to help our patients. However, when a cancellation occurs within 45 days prior to a scheduled session, spots are difficult to allocate for other patients because of prior planning for other families. You may request to move your session and we will do anything possible to accommodate your needs.

If the need to change the schedule occurs, we will move the session with the following penalties:

A rescheduling fee of \$500 will be charged on sessions moved 30-45 days prior and \$1000 rescheduling fee on sessions rescheduled 0-29 prior due to scheduled date.

If a deposit is made with Neu-Wellness Institute and the patient does not meet the criteria and/or the physician will not authorize participation in the program due to medical reasons, a full refund will be made within 30 days. Proper documentation will need to be submitted in order to process your refund.

Please sign and return this form with registration packet.

I agree with the refund and cancellation policy

Parent or Guardian Signature: _____

Date: _____

Patient Signature (If over 18 years of age): _____

Date: _____

Signer's Printed Name: _____



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NEU-WELLNESS REGISTRATION KIT AND CHECKLIST

We truly appreciate your having chosen Neu-Wellness Institute as a step to new beginnings. In order to provide our patients with the highest level of care, some information is helpful and needed.

Please send the enclosed registration packet to:

Neu-Wellness Institute

5359 Balboa Blvd.

Encino, CA 91316

Phone (310) 860-6110

Fax (310) 861-1462

E-mail: info@neuwellness.com

If you will be making payment with a credit card, please use the Credit Card Authorization Form.

Please use the check off list below to ensure you have completed your registration packet:

- Physician's Referral for Physical Therapy
- Physician's Referral for Speech, Language and Swallow Therapy
- Physician's Referral for Occupational Therapy
- Intake Form (3 pages)
- Consent Form
- Release Form
- Credit Card Form
- Change of Schedule / Refund Policy Form



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NEU-WELLNESS INSTITUTE CONSENT FORM

I, _____(Patient or Parent/Guardian) the undersigned, do hereby agree and give my consent for Neu-Wellness Institute to furnish me or my child with medical care and treatment that is considered necessary and proper in diagnosing and/or treating my physical condition.

I understand that there is a copy of the Notice of Privacy Practices, available for me to read. The HIPAA Privacy Notice describes the Practice's obligation to ensure the privacy of my health information. This HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask for clarification of it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of the HIPAA Privacy Notice.

I, _____ (Patient or Parent/Guardian) hereby release Neu-Wellness Institute owners & employees from any liability, claims, demands, and causes of action, now, or in the future, resulting from effects however caused, occurring during, or after mine or my child's participation in the exercise program.

In signing this Consent for Participation/Informed Consent Waiver, I hereby affirm that I have fully read the above statements and understand the inherent risks involved with participation in the Neu-Wellness Institute exercise program and agree / give permission for my child to participate. I have been informed of risks and complications that may occur and alternatives that may be available. I acknowledge that no guarantees, or assurances have been made to me / my child concerning the results intended from the treatment.

Parent or Guardian Signature: _____

Date: _____

Patient Signature: (If over 18 years of age) _____

Date: _____

Signer's Printed Name: _____

Address: _____

City: _____

State: _____

ZIP: _____

Phone: _____



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NEU-WELLNESS INSTITUTE CREDIT CARD INFORMATION

AMOUNT AND BILLING ADDRESS

By signing this form I authorize Neu-Wellness Institute to charge my Visa / Master Card / Discover / American Express a deposit in the amount of: _____

Name as appears on Card: _____

Billing address: _____

City: _____

State: _____

Zip: _____

CARD DETAILS AND SIGNATURE

Type (please check one): Visa ___ MasterCard ___ Discover ___ American Express ___

Credit Card Number _____

Expiration Date: _____

Security Code (on back of card): _____

Cardholder's signature

Date



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1. PATIENTS'S NAME _____

PARENT/GUARDIAN NAME _____

CONTACT INFORMATION _____

2. DIAGNOSIS _____

3. SURGICAL HISTORY _____

HISTORY OF BOTOX/PHENOL INJECTIONS _____

4. MEDICAL HISTORY

HISTORY OF SEIZURES (Y/N) _____ DATE OF LAST SEIZURE _____

ARE SEIZURES CONTROLLED BY MEDS? _____

SCOLIOSIS (Y/N) _____ DEGREE OF CURVATURE _____

HEART PROBLEMS/HYPERTENSION/PREVIOUS HEART SURGERIES _____

LUNG PROBLEMS _____

DIABETES _____

VISION/HEARING _____

SHUNTS (hydrocephalus) _____

TRACHEAL/G- TUBE _____

KIDNEY PROBLEMS _____

5. WHAT IS THE PATIENT'S: HEIGHT _____ WEIGHT _____

SHIRT SIZE _____ PANT SIZE _____

SHOE SIZE WITH AFO / SMO'S _____ SHOE SIZE WITHOUT AFO / SMO'S _____

CIRCUMFERENCE MEASUREMENTS OF: CHEST _____ WAIST _____



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6. PLEASE PROVIDE NAMES & PHONE NUMBERS TO ALL SPECIALISTS WHO TREAT THE PATIENT:

A. Orthopedic: Name: _____ Group practice name: _____

Address/Phone: _____

B. Pediatrician: Name: _____ Group practice name: _____

Address/Phone: _____

C. Neurologist: Name: _____ Group practice name: _____

Address/Phone: _____

D. Endocrinologist: Name: _____ Group practice name: _____

Address/Phone: _____

E. Orthotist: Name: _____ Group practice name: _____

Address/Phone: _____

F. Gastroenterologist: Name: _____ Group practice name: _____

Address/Phone: _____

7. PLEASE LIST ANY MEDICATIONS THE PATIENT IS CURRENTLY TAKING AND PURPOSE

8. PATIENT'S CURRENT ABILITIES (rolling, sitting, crawling, and walking) _____

9. WHAT CURRENT THERAPIES IS THE PATIENT RECEIVING? HOW OFTEN? OT/PT/ST _____

10. HAS THE PATIENT PREVIOUSLY ATTENDED AN INTENSIVE THERAPY SESSION? YES NO
IF YES - WHAT DATE(S)/LOCATION(S) AND CONTENT OF THE PROGRAM/TREATMENT
MODALITIES _____

11. LIST OF MEDICAL EQUIPMENT THAT THE PATIENT IS USING: (braces, walker, crutches,
wheelchair) _____

12. HOW DO YOU COMMUNICATE WITH THE PATIENT / HOW DO THEY COMMUNICATE
WITH YOU? _____



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13. IS THE PATIENT ABLE TO FOLLOW SIMPLE COMMANDS OR INSTRUCTIONS?

14. WHAT ARE THE GOALS FOR YOU'RE THE PATIENT TO ACCOMPLISH DURING AN INTENSIVE THERAPY SESSION? _____

14. ANY ADDITIONAL PERTINENT INFORMATION/COMMENTS _____

PLEASE PROVIDE US WITH A WRITTEN HIP X-RAY REPORT TAKEN WITHIN THE PREVIOUS 6 MONTHS ALONG WITH THIS FORM

Thank you kindly,
Neu-Wellness Institute.



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OCCUPATIONAL THERAPY PHYSICIAN REFERRAL FORM

Patient: _____

Date of Birth: _____

Diagnosis: _____

Rx: comprehensive physical therapy program

Frequency: 3-5 days/week

Duration: 3-4 weeks

Program: Occupational Therapy, Neuromuscular Education and Fitness activities utilizing suit therapy and universal exercise unit as specified by treating physical therapist

Physician's Signature: _____

Physician's Name: _____

Group practice name: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Date: _____

Stamp:



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PHYSICAL THERAPY PHYSICIAN REFERRAL FORM

Patient: _____

Date of Birth: _____

Diagnosis: _____

Rx: comprehensive physical therapy program

Frequency: 3-5 days/week

Duration: 3-4 weeks

Program: Physical Therapy, Neuromuscular Education and Fitness activities utilizing suit therapy and universal exercise unit as specified by treating physical therapist

Physician's Signature: _____

Physician's Name: _____

Group practice name: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Date: _____

Stamp:



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SPEECH, LANGUAGE AND SWALLOW PHYSICIAN REFERRAL FORM

Patient: _____

Date of Birth: _____

Diagnosis: _____

Rx: comprehensive physical therapy program

Frequency: 3-5 days/week

Duration: 3-4 weeks

Program: Physical Therapy, Neuromuscular Education and Fitness activities utilizing suit therapy and universal exercise unit as specified by treating physical therapist

Physician's Signature: _____

Physician's Name: _____

Group practice name: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Date: _____

Stamp:



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NEU-WELLNESS INSTITUTE RELEASE FORM

I hereby authorize the Neu-Wellness Institute to use the photographs and video taken of myself and/or of my minor child during the therapy/exercise sessions and any other activities or functions at Neu-Wellness Institute for educational, informational and promotional materials such as printed materials and websites.

Inclusion in the website and print material is strictly voluntary and is not paid for, endorsed, or compensated in any way.

In signing this document, I hereby affirm that I have read and fully understand above statements.

Parent or Guardian Signature: _____

Date: _____

Patient Signature (If over 18 years of age): _____

Date: _____

Signer's Printed Name: _____