



NEW PATIENT INFORMATION SHEET

HOW DID YOU HEAR ABOUT US? [] PHYSICIAN [] WEBSITE [] FACEBOOK [] SEMINAR [] NEWSPAPER AD [] FRIEND [] RETURNING PATIENT [] OTHER _____

Name (First) _____ (Middle) _____ (Last) _____ (Suffix) _____

Mailing Address _____

(City) _____ (State) _____ (ZIP) _____

Phone: Home _____ Cell _____ Work _____

Primary Phone _____ Email Address _____

Date of Birth _____ Age _____ Marital Status: [] Married [] Divorced [] Single [] Other [] Unknown

[] Widowed [] Separated Gender: [] Male [] Female Social Security # _____

Driver License # _____

Employment Status: [] Full Time [] Part Time [] Not Employed [] Self-Employed [] Retired [] Active Military [] Unknown [] Full Time Student

In case of emergency, please notify _____ Phone _____

Attorney involvement? [] Yes [] No Attorney name _____ Phone _____

Name of Employer, Parent or Guarantor _____

Street Address of Employer or Parent _____

City, State and ZIP of Employer or Parent _____

Name of Spouse _____ Spouse Date of Birth _____

Spouse's Employer _____ Phone _____

Have you received any therapy this year? [] Yes [] No

Have you been seen for nursing or physical therapy services in your home by a Home Health Agency prior to requesting services through our organization? [] Yes [] No If yes, name of home health agency _____

Primary Care Provider/Family Doctor _____ Phone _____

The two documents listed below are available for review at the Lake Centre for Rehab front office. Your signature below indicates agreement with the two forms listed below.

- 1. Authorization for Treatment, Assignment of Benefits, Payment Responsibility and Disclosure of ALF Resident Information.
2. Acknowledgement of Receipt of Privacy Notice in combination with Voluntary Consent.

The listed individuals may have access to my PHI (Protected Health Information): _____

Patient/Representative Signature _____ Date _____

Witness _____ Date _____

Guardian Signature if patient is a minor _____ Date _____

Relationship to Patient _____

AUTHORIZATION
FOR
TREATMENT, ASSIGNMENT OF BENEFITS, PAYMENT RESPONSIBILITY
AND DISCLOSURE OF ALF RESIDENT INFORMATION

1. I hereby consent to treatment by Rehab Therapy Works (“RTW”) as outlined in the treatment Plan of Care developed in collaboration with my attending physician.
2. **MEDICARE:** Patients who are covered by Medicare are responsible for their annual deductible and the 20% portion of the Medicare allowed benefit amount for covered services. I understand Medicare does not pay for all of my therapy costs. Medicare only pays for 80% of the covered benefit. My covered outpatient therapy benefit is as stated in the federal guidelines, unless I qualify for an exception to the benefit limit. If I receive therapy service that is not a Medicare covered benefit, I am responsible for payment, personally or through any other insurance I may have. The purpose of this notification is to help me make an informed choice about whether or not I want to receive therapy services, knowing I may have to pay for the services myself. I understand that RTW will bill my secondary insurance carrier. I authorize RTW to furnish my insurance company any information needed to process the claim. I assign to RTW all money paid for the rehabilitation services furnished. I agree to pay all deductibles, co-insurance and non-covered items not paid for by my secondary insurance carrier. I will notify RTW if I am eligible for coverage with Tricare for Life Health Care System. I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of any medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to RTW.
3. **PRIVATE:** I understand that every effort will be made by RTW to bill my insurance carrier for services rendered. I authorize RTW to furnish my insurance company any information needed to process the claim. I assign to RTW all money paid for the rehabilitation services furnished. RTW DOES NOT accept assignment on non-contracted claims. Any amount not paid by my insurance company is my direct responsibility. I also understand that it is my responsibility to see that all claims are paid within 30 days of receipt. If claims are not paid by 60 days, I will be responsible for payment of the claim (IN FULL) at that time. Any balance due after 60 days may be subject to a delinquency fee of 1% per month. I understand that health and accident insurance policies are an arrangement between my insurance company and myself, that all services rendered me are charged directly to me, and that I am personally responsible for payment.
4. **WORKERS’ COMPENSATION:** Patients who are covered under Workers’ Compensation are not financially responsible for services rendered unless their claim is controverted/denied. If this occurs, I understand that I am immediately responsible for all controverted/denied charges regardless of pending litigation.
5. **MANAGED CARE PLANS:** Patients who are covered under a participating Managed Care Plan are responsible for any applicable deductibles and/or co-payments required under their plan. I understand that I am responsible for payment of any applicable deductibles and/or co-payments under my plan at the time services are rendered.
6. I, and Patient if applicable, agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable Powers of Attorney, Health Care Surrogate forms or Court Orders appointing the undersigned as the legal guardian of the Patient.
7. I UNDERSTAND THAT IF I FAIL TO MAKE MY APPOINTMENT AT THE TIME RESERVED FOR ME, WITHOUT A 24-HOUR PRIOR NOTICE, I WILL BE SUBJECT TO A \$25.00 FEE. If I do not show up for three (3) appointments, I may forfeit all subsequent appointments and be discharged or placed on a call list for open appointment times if available.
8. I agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provisions of Paragraphs 2, 3, 4, 5, 6, 7 and 8 shall survive any such termination.
9. **Your signature at the bottom of the New Patient Information Sheet indicates your agreement with the above terms.**

SCREENING FORM

Patient Name

Facility

Effective January 1, 2020, the Medicare “Cap” starts at \$2,080 for physical and speech therapy services combined, and \$2,080 for occupational therapy services, billed by an outpatient provider for the purposes of applying the KX modifier. Each provider is required to track the entire therapy episode, regardless of setting. When the Cap exceeds \$3,000, there may be additional scrutiny of the claim by Medicare for medical necessity. Services can only be denied for medical necessity reasons.

Previous Therapy

1. Since the first of the year, have you received Part B therapy services in a skilled nursing facility?

Yes No If yes, by whom and how much? _____

2. Since the first of the year, have you received Part B therapy services in a physician’s office?

Yes No If yes, by whom and how much? _____

3. Since the first of the year, have you received Part B therapy services in an outpatient clinic?

Yes No If yes, by whom and how much? _____

4. Since the first of the year, have you received Part B therapy services in your home? Yes No

If yes, by whom and how much? _____

Previous Home Health

Are you currently receiving home health services for nursing, or physical, occupational or speech therapy, from a home health agency? Yes No

Signing below indicates that the answers above are true and correct, and that the information is complete to the best of the signor’s knowledge.

Patient Signature

Witness Signature

Date

Date



MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient _____

Medicare # _____ Admit/Eval Date _____

Facility _____ Provider # _____

- 1. Is the patient covered by Veterans Administration or Black Lung?
2. Was illness due to an injury?
3. Is the patient employed (Medicare disabled beneficiaries under the age of 65 or Medicare over the age of 65) and covered by a group health plan?
4. Is the patient entitled to benefits solely on the basis of end stage renal disease?

If you answered yes to any of the above questions, you will need to fill out the information requested below.

Insurance company _____

Address _____

Policy/certificate number _____

Group name _____

Group number _____

PATIENT SIGNATURE _____ DATE _____

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Relationship to patient _____

Signature of person completing this form _____ Date _____
(If other than the patient)

Acknowledgement of Receipt of Privacy Notice in Combination with Voluntary Consent

Acknowledgement:

As a patient of Rehab Therapy Works, I have been provided with its **Notice of Privacy Practices** which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge that I have received the **Notice of Privacy Practices** and understand how medical information about me may be used, the duties of Rehab Therapy Works, and my rights to privacy protection and access to my medical information. I understand that the office manager of Rehab Therapy Works is available to answer any questions that I may have regarding issues of privacy.

Consent:

I give consent for medical information about me to be used and disclosed for purposes of treatment, payment or health care operations. I understand that the privacy regulations allow Rehab Therapy Works to use or disclose my medical information for these purposes, and that my consent is not required. Rehab Therapy Works is obtaining my consent to provide additional assurance regarding the privacy of my medical information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that Rehab Therapy Works may choose not to agree to the request for a restriction on the uses or disclosures of my medical information for purposes of treatment, payment or health care operations.

To make a request to revoke my consent, I must complete and sign a “Request to Restrict Uses and Disclosures of Protected Health Information” form and return it to the office manager at Rehab Therapy Works. I may obtain a copy of the form from the office manager at the Rehab Therapy Works location at which I am being treated.

Patient Name _____

Date _____

Have you recently traveled out of this country? Yes No
Have you had direct/indirect prolonged contact with someone with a confirmed case of coronavirus? Yes No

PAST MEDICAL HISTORY

 Please check any of the following conditions you have, or have had **-OR-** No medical history to report

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease | the following? (Check all that apply) <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/> Endometriosis <input type="checkbox"/> Trouble with your period <input type="checkbox"/> Complicated pregnancies or deliveries <input type="checkbox"/> Pregnant or think you may be <input type="checkbox"/> Other gynecological or obstetrical difficulties? If yes, please describe _____ _____ _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Clotting disorder (blood clot) | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cataracts | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Glaucoma | _____ | |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Gout | _____ | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | | |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> High cholesterol | | |
| <input type="checkbox"/> Nerve/muscle disease | <input type="checkbox"/> Osteoporosis | | |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizures | | |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Sickle cell anemia | | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke | | |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Substance abuse | | |

For men only: Have you been diagnosed with prostate disease? Yes No

For women only: Have you ever been diagnosed with any of

PAST SURGICAL HISTORY

 Please check any surgery you have had **-OR-** Never had surgery

- | | |
|---|--|
| <input type="checkbox"/> Breast surgery Year _____ | <input type="checkbox"/> Tubes tied Year _____ |
| <input type="checkbox"/> Open heart or bypass surgery..... Year _____ | <input type="checkbox"/> Hysterectomy..... Year _____ |
| <input type="checkbox"/> Gall bladder Year _____ | <input type="checkbox"/> Heart valve replacement..... Year _____ |
| <input type="checkbox"/> Colon surgery..... Year _____ | <input type="checkbox"/> Orthopaedic surgery..... Year _____ |
| <input type="checkbox"/> Fracture surgery Year _____ | <input type="checkbox"/> Orthopaedic surgery..... Year _____ |
| <input type="checkbox"/> Hernia repair Year _____ | <input type="checkbox"/> Orthopaedic surgery..... Year _____ |
| <input type="checkbox"/> C-section Year _____ | <input type="checkbox"/> Orthopaedic surgery..... Year _____ |
| <input type="checkbox"/> Pacemaker Year _____ | <input type="checkbox"/> Other..... Year _____ |
| <input type="checkbox"/> Metal implants Year _____ | <input type="checkbox"/> Other..... Year _____ |
| <input type="checkbox"/> Spine surgery Year _____ | <input type="checkbox"/> Other..... Year _____ |

CURRENT MEDICATIONS

-OR- No medications

| Medication | Strength | How Often? |
|------------|----------|------------|
| | | |
| | | |
| | | |
| | | |
| | | |

ALLERGIES/SENSITIVITIES

-OR- No known allergies/sensitivities

| Allergic/Sensitive To | Reaction | Allergic/Sensitive To | Reaction |
|-----------------------|----------|-----------------------|----------|
| Latex | | Other: | |
| Adhesives/tapes | | Other: | |
| Bees | | Other: | |
| Lotions/creams | | Other: | |

Patient Name _____

Date _____

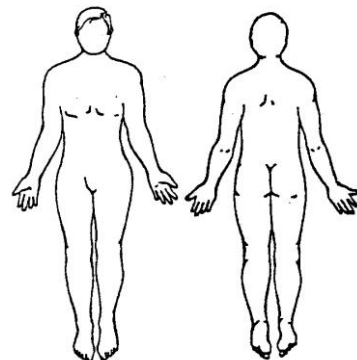
REVIEW OF SYSTEMS

Please indicate if you are currently experiencing any of the following conditions:

| | | | | | | | | | |
|--|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|--------------------------------|--|--------------------------|--------------------------|
| <u>Constitutional</u> | Y | N | | Y | N | | Y | N | |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> | Foot/ankle swelling | <input type="checkbox"/> | <input type="checkbox"/> | | Difficulty rising from low seat | <input type="checkbox"/> | <input type="checkbox"/> |
| Chills | <input type="checkbox"/> | <input type="checkbox"/> | | | | <u>Respiratory</u> | Y | N | |
| Unintentional weight loss | <input type="checkbox"/> | <input type="checkbox"/> | Cough | <input type="checkbox"/> | <input type="checkbox"/> | | <u>Neurological</u> | Y | N |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | | Tingling/numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| Profuse sweating | <input type="checkbox"/> | <input type="checkbox"/> | Phlegm production | <input type="checkbox"/> | <input type="checkbox"/> | | Tremors | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | | Speech change | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Skin</u> | Y | N | Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | | Hand, arm or leg weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Rash | <input type="checkbox"/> | <input type="checkbox"/> | | | | <u>Gastrointestinal</u> | Y | N | |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | | Loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Nausea | <input type="checkbox"/> | <input type="checkbox"/> | | Vertigo/spinning | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Head, Ears, Nose & Throat</u> | Y | N | Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | | Unbalanced/unsteady | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain | <input type="checkbox"/> | <input type="checkbox"/> | | Lightheadedness | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing loss | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | | <u>Psychiatric</u> | Y | N |
| Ear pain | <input type="checkbox"/> | <input type="checkbox"/> | Blood in stool | <input type="checkbox"/> | <input type="checkbox"/> | | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear discharge | <input type="checkbox"/> | <input type="checkbox"/> | Dark tarry stools | <input type="checkbox"/> | <input type="checkbox"/> | | Suicidal ideas | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose bleeds | <input type="checkbox"/> | <input type="checkbox"/> | Bladder incontinence | <input type="checkbox"/> | <input type="checkbox"/> | | Substance abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestion | <input type="checkbox"/> | <input type="checkbox"/> | Bowel incontinence | <input type="checkbox"/> | <input type="checkbox"/> | | Hallucinations | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | | | | | Nervous/anxious | <input type="checkbox"/> | <input type="checkbox"/> |
| Sore throat | <input type="checkbox"/> | <input type="checkbox"/> | | | | | Sleeping disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | | Memory loss | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Eyes</u> | Y | N | <u>Genitourinary</u> | Y | N | | | | |
| Blurred vision | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination | <input type="checkbox"/> | <input type="checkbox"/> | | MISCELLANEOUS | | |
| Double vision | <input type="checkbox"/> | <input type="checkbox"/> | Urgency | <input type="checkbox"/> | <input type="checkbox"/> | | <u>Living Environment</u> | | |
| Sensitive to light | <input type="checkbox"/> | <input type="checkbox"/> | Frequency | <input type="checkbox"/> | <input type="checkbox"/> | | With whom do you live? | | |
| Eye pain | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Alone | | |
| Eye discharge | <input type="checkbox"/> | <input type="checkbox"/> | Side pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Spouse and /or other | | |
| Eye redness | <input type="checkbox"/> | <input type="checkbox"/> | | | | | <input type="checkbox"/> Child/children at home | | |
| | | | <u>Musculoskeletal</u> | Y | N | | | | |
| <u>Cardiovascular</u> | Y | N | Muscle pain | <input type="checkbox"/> | <input type="checkbox"/> | | Where do you live? | | |
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | Neck pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Private home | | |
| Pounding heart | <input type="checkbox"/> | <input type="checkbox"/> | Back pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Assisted living | | |
| Shortness of breath relieved by sitting up | <input type="checkbox"/> | <input type="checkbox"/> | Joint pain | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Shortness of breath during sleep/rest/activity | <input type="checkbox"/> | <input type="checkbox"/> | Falls | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| Calf pain with activity | <input type="checkbox"/> | <input type="checkbox"/> | Weakness in arms or legs | <input type="checkbox"/> | <input type="checkbox"/> | | How do you rate your general health? | | |
| | | | Lack of coordination | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor | | |
| | | | Difficulty walking | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| | | | Night pain | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

**Your current pain: Indicate where your pain is located on the diagram.
Do not indicate areas of pain that are not related to your current problem.**

KEY: 0000 = Pins & Needles
 xxxx = Burning
 //// = Stabbing
 ---- = Numbness



Patient Name _____

Date _____

CURRENT PROBLEM

Reason for today's visit _____ Date of onset _____

Is this visit due to injury or accident? Yes No Date of injury _____ Date of surgery _____What treatment or tests have you had for this current problem? Surgery CT MRI
 X-Ray Injection Splint/braceAre you self-medicating with any of the following? Anti-inflammatory (Ibuprofen/Motrin/Advil)
 Acetaminophen (Tylenol)
 Other pain medication _____Have you received therapy for the current or other problem in the past year? Yes No If yes, indicate below:

| | <u>Date</u> | <u># of Visits</u> | | <u>Date</u> | <u># of Visits</u> |
|---|-------------|--------------------|---------------------------------------|-------------|--------------------|
| <input type="checkbox"/> Physical therapy | _____ | _____ | <input type="checkbox"/> Chiropractor | _____ | _____ |
| <input type="checkbox"/> Occupational therapy | _____ | _____ | <input type="checkbox"/> Massage | _____ | _____ |
| <input type="checkbox"/> Speech therapy | _____ | _____ | <input type="checkbox"/> Acupuncture | _____ | _____ |
| <input type="checkbox"/> Skilled nursing facility | _____ | _____ | | | |

What activities make your pain worse? _____What activities make your pain better? _____

How far can you walk? _____ What stops you? _____

What are you unable to do because of your current problem? _____

Have you had this problem before? Yes No If yes, when? _____

What did you do about it? _____

Pain rating, on a scale of 0 to 10: 0 = NO PAIN 10 = THE WORST PAIN IMAGINEABLE

How would you rate the intensity of your pain during the last 1 to 2 weeks?

| | | | | | | | | | | | |
|----------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|
| Current: | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 |
| Lowest: | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 |
| Highest: | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 |

Since the problem began, has the problem become: Worse Better Unchanged

What are your goals for treatment? _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

INSTRUCTIONS

Before your first visit, download the patient forms from our website at www.myrtw.com/forms.

On your first visit, please remember to bring the following:

1. Physician or NPP (Non-Physician Provider) order for therapy.
2. *Bring the patient forms you filled out*
3. Insurance cards (primary and secondary).
4. Photo ID.
5. Current list of medicines and allergies.
6. Recent reports that you might have, including x-rays, MRI's, surgeries, etc.
7. Loose-fitting, comfortable clothing.
8. Supportive closed-toe shoes.
9. Bring in any adaptive devices currently used, such as braces, canes, walkers, etc.
10. Copy of home health discharge with name and phone number of home health agency if applicable.
11. Notify us of implants and pacemakers (defibrillators).

Due to allergies of staff members and patients, please refrain from strong fragrances.