Physical Therapy of Concordia

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____ Address 2 _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ First Name _____

Relationship _____ Phone _____

Employer

Name _____ Work Phone _____

Address _____ Address 2 _____

City _____ State _____ Zip _____

Primary Insurance

Insurance _____ ID _____ Group # if applicable _____

Insurance Phone _____ Subscriber Name _____ Date of Birth _____

Secondary Insurance

Insurance _____ ID _____ Group # if applicable _____

Insurance Phone _____ Subscriber Name _____ Date of Birth _____

I authorize release of information requested by my insurance plan for payment.

I understand that I am financially responsible for any balance due.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Witness: _____ Date: _____

Patient Signature: _____ Date: _____

Pelvic Floor Physical Therapy Intake Form

Name: _____ Date of Birth: _____ Today's Date: _____

Why did the doctor send you to therapy? _____

When did it begin? _____ Is it getting: Better Worse Staying the same (Circle One)

Pain: Please rate your pain (0 = no pain, 10 = worst pain imaginable)

Current: _____ At worst: _____ At best: _____ Location: _____

When do you experience pain: _____

If you are sexually active, please circle which (if any) apply to your current condition (Marinoff Scale):

N/A: Not sexually active **0:** no pain or difficulty with intercourse

1: causes discomfort, but does not interfere with frequency of intercourse

2: sometimes prevents intercourse **3:** completely prevents intercourse

Medical History:

Past medical history: _____

Any current or previous CANCER (if yes, where): _____

Number of pregnancies: _____ Number of vaginal births: _____ C-sections: _____

Age of youngest child: _____ Any pregnancy/delivery complications: _____

Surgeries on belly/pelvis/hips: _____

Bowel and Bladder Habits:

Circle any of the following that you regularly experience: CONSTIPATION DIARRHEA

URINE LEAKAGE BOWEL LEAKAGE PRESSURE/FALLING OUT SENSATION

DIFFICULTY EMPTYING (Bowel/Bladder) DIFFICULTY STARTING (Bowel/Bladder)

How many times do you go to the bathroom during the day (on avg)? _____ At night? _____

Do you experience leakage with any of the following (circle all that apply):

COUGHING SNEEZING LAUGHING EXERCISE/RUNNING

ON THE WAY TO THE BATHROOM AS A CHILD

AFTER USING THE BATHROOM WITH SEXUAL INTERCOURSE

How many times per week do you have a bowel movement? _____

Most frequent stool consistency? _____ →

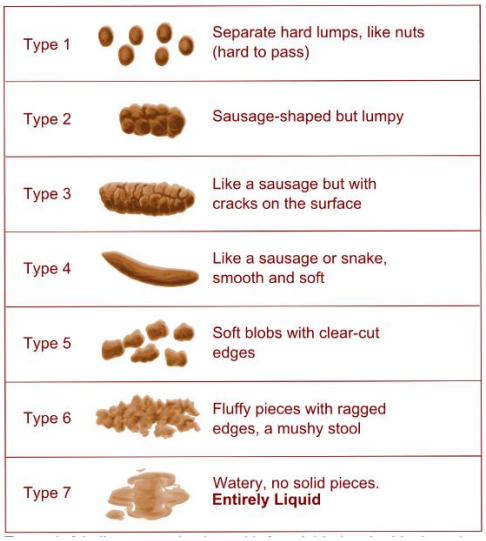
Anything else the therapist needs to know: _____

_____

_____

_____

Bristol Stool Chart



Pelvic Floor Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficultly with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure. I would like another staff member in the procedure room with me. Yes / No

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent or Guardian (if applicable) _____

Witness Signature: _____

Physical Therapy of Concordia

Patient Rights & Responsibilities

1. The patient has a right to considerate and respectful care.

2. The patient has the right to receive his/her therapist(s) complete and current information concerning the diagnosis, treatment and prognosis in terms the patient can reasonably be expected to understand.

3. The patient has the right to receive from his/her therapist(s) information necessary to give informed consent prior to the start of any procedure and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of this action.

5. The patient has the right to every consideration of his/her privacy concerning his/her own medical care program.

6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential.

7. The patient has the right to expect that within its capacity, the clinic will make reasonable effort to respond to the request/need of a patient for services.

8. The patient has the right to obtain information as to any relationship of the clinic to other health care and educational institutions insofar as his/her care is concerned.

9. The patient has the right to expect reasonable continuity of care.

10. The patient has the right to examine and receive an explanation of his/her bill regardless of source of payment.

11. The patient has the right to be informed of charges or services not covered by Medicare or any federally funded programs.

12. The patient has the right to have his/her spiritual, religious and cultural needs recognized.

13. The patient has the right to know what clinic rules and regulations apply to his/her conduct as a patient.

14. The patient is responsible for following clinic guidelines affecting patient care and the rights of other patients.

15. The patient is responsible for interacting with clinic staff in a considerate and respectful manner.

16. The patient is responsible for following the treatment plan recommended by the physician(s), therapist(s) responsible for his/her care.

17. The patient has the right to be informed of any human experimentation or other research or educational projects affecting his/her care.

18. The patient has the right to file a grievance with the Administrator if he/she feels his/her rights have been violated in any way.

Date _____ Patient Signature _____

Physical Therapy of Concordia

PAYMENT POLICY & BILLING PROCEDURES

1. Unless 100% coverage has been verified, you are responsible for the percentage &/or deductible not covered by your insurance company. This payment is requested during each visit.
2. If insurance information is not available or you do not have insurance, payment is due in full unless other arrangements have been approved by our Centralized Billing Office (CBO).
3. You will receive a monthly statement which will show you the status of your account.
4. We accept VISA, MasterCard, and Discover bankcards.
5. There is a $35 charge for all returned checks.

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. Many Insurance companies have stipulations, such as usual & customary fees (UCR), limited therapy sessions, limited reimbursable amounts per session, deductibles, co-payments, supplies, etc. Such stipulations should be indicated in your policy manual.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED by your insurance. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.

Worker's Compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will become YOUR RESPONSIBILITY.

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to Physical Therapy of Concordia. PT of Concordia has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payment policy & billing procedures of PT of Concordia. I hereby authorize PT of Concordia to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign PT of Concordia all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to PT of Concordia. It is understood that any money received from the above named parties over & above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to PT of Concordia for charges not covered by my insurance company. I certify by my signature.

Signature:	Date:
Relationship to Patient (self, parent, guardian, spouse, etc.):	
Witness:	

Physical Therapy of Concordia

Patient Cancellation & No-Show Policy

Your scheduled appointment is a specific time that your therapist will spend with you. We will attempt to be as flexible as possible with scheduling your appointments. Your therapist attempts to be respectful of your time by starting your treatment when it is scheduled. Please help us maintain this schedule by arriving on time. If you are unable to arrive on time for your appointment, please call and reschedule. If you are more than 15 minutes late for your scheduled appointment, we may need to reschedule your appointment.

Cancellation or failure to attend three consecutive appointments will result in termination of your therapy program. To restart your therapy you must return to your physician for a new prescription and obtain additional authorization from your insurance company.

IN THE EVENT THAT YOU ARE COVERED BY WORKER'S COMPENSATION and fail to keep the appointments as recommended by your physician, the appropriate parties will be notified of your absence in writing. Typically, the notification will be to your physician, insurance carrier, employer and rehabilitation consultant. Each cancelled and no/show appointment will also be noted in your chart. Please understand that failure to actively participate in your rehabilitation program may result in the impression that you are disinterested in your recovery and are better and able to return to work. Failure to attend therapy may have a negative effect on your workers' compensation coverage.

Thank you for your assistance.

Patient Signature: _____ Date: _____

Physical Therapy of Concordia

Privacy Practices

***CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION*:**

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION
Your protected health information will be used by Physical Therapy of Concordia or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice as described in detail on the previous page.

NOTICE OF PRIVACY PRACTICES
You should review this document for the complete description of how your protected health information may be used or disclosed.

REQUESTING A RESTRICTION ON THE USE OF DISCLOSURE OF YOUR INFORMATION:
You may submit a request in writing as outlined above to restrict your information, however, Physical Therapy of Concordia may or may not agree to restrict the use or disclosure of your protected health information. If Physical Therapy of Concordia agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT:
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES:
Physical Therapy of Concordia reserves the right to modify the privacy practices outlined in this notice.

SIGNATURE: I have reviewed this document and give my permission to Physical Therapy of Concordia to use and disclose my health information in accordance with it.

Name of Patient (print, please)

Signature of Patient Date

Signature of Patient Representative Relationship to patient