PATIENT INFORMATION **EMAIL ADDRESS:**

First Name: | Last Name: | Middle Initial: | Date: / /

Address: | City: | State: | Zip:

Birth date: / / | Age: | ☐ Male ☐ Female | S.S. #: - -

Home Phone: ( ) - | Alternative Phone (Cell, Pager): ( ) - | Spouse:

Chose Clinic Because/ Referred to Clinic By ☐ Dr.: ☐ Insurance Plan ☐ Family ☐ Friend

☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:

WORK INFORMATION

Employer: | Work Phone ( ) - | Ext.

Occupation: | Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION

Referring Dr: | Referring Dr. Phone: ( ) -

Regular Dr./PCP | Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

Primary Insurance Name:

Subscriber's Name (If different): | Birth date : / /

ID. #: | Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of Secondary Insurance:

Subscriber's Name: | Birth date : / /

ID. #: | Group/Policy #

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

AUTO OR WORK INJURY CLAIM **(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**

Insurance Name: ☐ Auto : ☐ Labor & Industries:

Adjuster/Claim Manager: | Phone: | Ext.:

Address: | City | State: | Zip:

Claim #: | Accident Date: / / | Cause:

ATTORNEY INFORMATION

Name: | Law Firm: | Phone: ( ) -

Address | City | State: | Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):

Relationship to Patient: | Home Phone: ( ) - | Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Searcy Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Searcy Physical Therapy to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

PATIENT QUESTIONNAIRE: FEMALE PELVIC HEALTH

Name: ________________________________ **Age:** _____ **DOB:** _____________

Referring Doctor: ____________________ **Diagnosis:** ______________________________

Have you received previous Physical Therapy for this problem? (circle) No OR Yes: (date):__________

Have you received other treatment for this problem? No OR Yes: (type)______________________

Medical History (circle all that apply): heart problems / hypertension / diabetes / cancer / osteoporosis thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis rheumatoid arthritis / seizures / history of stroke / kidney problems / depression / hx of blood clots/DVT

Other:____

Surgical History (list type & date): ____

____

Gynecological History (fill in blanks or circle answer for all that apply): Number miscarriages_______

Number of pregnancies______ . Number of vaginal deliveries________ . Number of C-sections_______

Birthdates & weight of each baby: ____

History of sexually transmitted diseases: No OR Yes: (specify active infections)________________

History of chronic urinary / bladder / yeast infections? No OR Yes: (specify)__________________

Any active infections at this time? No OR Yes: (specify type/treatment)______________________

Approximate date last menstrual cycle:_______ Menopausal? No OR Yes(hormone replacement?_____)

(Circle any that apply): Feelings of pelvic heaviness / history of: fibroids / cysts / endometriosis

Current Medications: ____

Allergies: ____

Work Status: ☐ currently working ☐ retired ☐ temporarily off work ☐ unemployed ☐ other:

Location / type of work: ____

++

Emergency Contact:

Name: ________________________________ Daytime phone #: (____)_______ -_________

++

How did you learn about us? ☐ friend ☐ physician ☐ internet ☐ advertisement ☐ other:

Date of your next doctor's appointment: ________________________

______________________________ ______________________

Patient's Signature **Date**

PELVIC HEALTH REHAB: SYMPTOM QUESTIONNAIRE

Urinary Symptoms: Check all that apply and fill in appropriate blanks.

___ Urgency: abnormally strong urges to urinate
___ Frequency: urinates _____ times per (circle one) hour / day.
___ Leaking: When I leak, it (circle all that apply)
dampens underwear / dampens outerwear / empties my bladder completely.
___ Leaking: I leak with (circle all that apply): a strong urge to urinate / lifting / coughing
laughing / sneezing / bending / standing up / opening door to house / parking car
on way to bathroom / walking / jogging/exercise / sexual intercourse / hear running water
other:____
___ Leaking: I leak _______ times a (circle one) day / week.
___ Use of leakage protection (number per day): panty liner____ / pad____ / diaper_____
___ Wake at night to urinate: number of times each night: ______
___ Burning with urination
___ Abnormal stream (specify:____)
___ Difficulty or hesitancy with emptying bladder

Other:____

Fluid Intake: Fill in *average number of cups* (1 cup=8 ounces) of each for a normal day:

___ Water ____ Milk ____ Juice (specify:____________________)
___ Soft Drinks ____ Decaf Soft Drinks ____ Tea
___ Decaf Tea ____ Coffee ____ Decaf Coffee
___ Alcohol ____ Other:___________________________

Bowel Symptoms: Check all that apply and fill in blanks.

Number of bowel movements per (circle one) day / week : ______

___ Constipation: I frequently strain to move bowels because of this: Yes OR No
___ Take regular fiber supplements (type and frequency):________________________
___ Frequent diarrhea
___ Irritable bowel syndrome
___ Lactose intolerance or other food allergy affecting bowels (specify other: ______________)
___ Bowel leakage (circle all that apply): stains underwear / small amount / large amount
___ Bowel leakage (circle all that apply): I leak with lifting / coughing / laughing / sneezing /
bending / standing up / walking / jogging/exercise / sexual intercourse
other:____
___ Bowel leakage: I leak _______ times a (circle one) day / week.
___ Use of leakage protection (number per day): panty liner____ / pad____ / diaper_____

Other: ____

Pain Symptoms:

Do you have pain? No OR Yes: location:_______________________________
Describe how the pain feels: _______________________________
When did pain first begin: _______________________________
Are any of your normal activities limited by pain? No OR Yes: (specify)________________
What makes your pain worse?:_______________________________
Better?: _______________________________

Rate your pain on the following scale: 0=no pain at all, 5=moderate pain, 10=worst pain imaginable

At worst (circle one): 0 1 2 3 4 5 6 7 8 9 10 On average: 0 1 2 3 4 5 6 7 8 9 10

Goals you want to achieve through therapy (be specific): ____________________
____

PELVIC FLOOR CONSENT FOR EVLAUATION 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; difficulty 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 initial 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 the 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 and ______choose or ______refuse this option.

______________________________	______________________
Signature of Patient or Personal Representative	Date
______________________________	______________________
Name of Patient or Personal Representative	Date
______________________________	______________________
Witness Signature	Date

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I consent to the disclosure of my Protected Health Information (PHI) by Searcy/Des Arc Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Searcy/Des Arc Physical Therapy. I understand that diagnosis or treatment of be by Searcy/Des Arc Physical Therapy may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI information is used or disclosed to carry out treatment, payment, or health care operations of this practice.

Searcy/Des Arc Physical Therapy is not required to agree to the restrictions that I may request. However, if Searcy/Des Arc Physical Therapy agrees to a restriction that I request, the restriction is binding on Searcy/Des Arc Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that Searcy/Des Arc Physical Therapy has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review Searcy/Des Arc Physical Therapy's Notice of Privacy Practices (NPP) prior to signing this document. The NPP describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my therapy services, or in the performance of health care operations of Searcy/Des Arc Physical Therapy. The NPP of Searcy/Des Arc Physical Therapy is provided at 801 W. Beebe Capps Expy, Searcy, AR 72143 / 1108 Hwy 11 N. Suite B, Des Arc, AR 72040. This NPP also describes my my rights and Searcy/Des Arc Physical Therapy's duties with respect to my PHI.

Searcy/Des Arc Physical Therapy reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

________________________________ ____________________

Signature of Patient or Personal Representative Date

________________________________ ____________________

Name of Patient or Personal Representative Date

ADDENDUM: PATIENT PRIVACY

Patient's Name:____

Date of Birth:____

Social Security Number:______________________________________

In an effort to comply with current **HIPAA** (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person other than your doctor with whom we may discuss your private health information or financial matters:

Name:____________________ Phone:____________________ Relationship:______________

Name:____________________ Phone:____________________ Relationship:______________

Name:____________________ Phone:____________________ Relationship:______________

In the event that we are unable to reach you personally, do you give your permission to a staff member of Searcy/Des Arc Physical Therapy to leave a message on your answering machine, voicemail, and/or with someone at your home/cell number concerning your private health information or financial matters? (Check yes or no)

YES_______ NO_______

I understand that I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other do not divulge or use the information in any way without discussing with me first.

Automated Reminders: Consistency is a vital component to successful therapy. As a courtesy to patients, Searcy Physical Therapy will routinely send automated text or voice recorded messages reminding patients of upcoming appointments. Please choose one of the following preferences for text or voice reminders:

- ☐ I prefer to receive reminders via text message at the following number: ____________________
- ☐ I prefer to receive reminders via voice message at the following number: ____________________
- ☐ I prefer not to receive reminders via text or voice message.

______________________________________ ______________________________

Signature of Patient or Legally Authorized Individual Date

____

Relationship to patient if signed by anyone other than the patient
(Such as: Parent, Legal Guardian, Personal Representative, etc.)

Acknowledgement of Patient's Financial Responsibility

I understand that Searcy Physical Therapy will call to confirm insurance benefits before my first appointment as a courtesy. I understand that it is highly recommended that I also call to confirm benefits as policy holders sometimes have access to privileged information that providers do not.

I understand that verification of insurance benefits does not guarantee payment.

I understand that I will be financially responsible for any charges not covered by my insurance company. Many insurance policies require some patient responsibility in the form of a copay, deductible, coinsurance or some combination thereof.

I understand copays are due at the time of each appointment. I understand that I will be billed for any portion of charges my insurance assigns as patient responsibility as claims are processed.

I authorize the release of any medical information necessary to process insurance claims for services and / or supplies provided by Searcy Physical Therapy / Des Arc Physical Therapy.

I authorize payment of medical benefits to Andrew Abraham, PT, PA /dba, Searcy Physical Therapy / Des Arc Physical Therapy.

_________ I would like to bill my insurance

_________ I would like to be a self-pay patient.

______________________________________ ___________________________

Signature of Patient or Personal Representative Date

____

Printed Name of Patient

APPOINTMENTS, CANCELLATIONS AND NO SHOW POLICY

PLEASE READ CAREFULLY

The therapists and staff of Searcy Physical Therapy are glad you are here. *You* are the reason this physical therapy practice exists, and we promise to never forget that! Your successful rehabilitation is our top priority. To achieve the best possible outcome we and/or your doctor have recommended a particular treatment schedule. To attain these results, it is very important that you attend your therapy sessions as scheduled.

<u>No Shows:</u> If you are unable to keep a scheduled appointment, please let us know **2 hours in advance**. A **NO SHOW** is when a patient fails to keep a scheduled appointment or does not notify our office at least 2 hours in advance. Please note that our office must be notified directly. Texting or calling your therapist on their personal cell is not considered notifying us as they can't always notify the office staff if they're treating other patients.

We ask patients to try to never no show for an appointment. We promise to value your time and ask for the same courtesy. If a patient no shows for more than one appointment, they can then only schedule same day appointments. The patient will need to call on a day they'd like to come and see if there are any openings available that day. If the patient then continues to no show or cancel appointments with less than 2 hours notice, we will no longer be able to treat them at Searcy Physical Therapy.

<u>Chronic Cancellations:</u> It is common practice for us to schedule patients' appointments for several weeks out as a courtesy and convenience for patients who know they want to come at the same time every week. However, we will not be able to provide this service to patients who chronically cancel or reschedule appointments. For this purpose, we define "chronic" as routinely cancelling or rescheduling one appointment, or more, per calendar week. If a patient cancels or reschedules with this frequency, we will need to cancel all their future scheduled appointments and begin scheduling only a maximum of two appointments at a time (each time the patient comes for an appointment, we'll schedule their next one to two appointments).

<u>Workers' Compensation and Personal Injury:</u> Worker's Compensation and Personal Injury patients' documents of any missed or cancelled appointments are forwarded to your case manager and primary care doctor. This could jeopardize your claim and prolong or stop any benefits that you may be entitled to.

<u>Emergencies:</u> We understand that sometimes emergencies happen. Please always give our office as much notification as possible about any appointment you will miss when an emergency happens. Searcy Physical Therapy may waive the above policy at their discretion when they deem a situation as emergent.

We appreciate the opportunity to provide you with uncompromising care. Thank you for your consideration of our staff and other patients.

Signing below indicates you understand and agree to the terms of this policy.

________________________________ ________________________

Signature of Patient or Personal Representative Date

________________________________ ________________________

Name of Patient or Personal Representative Date