



PATIENT INFORMATION **EMAIL ADDRESS:**

First Name:		Last Name:		Middle Initial:		Date: / /	
Address:				City:		State:	Zip:
Birth date: / /		Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female		S.S. #: - - -		
Home Phone: () -			Alternative Phone (Cell, Pager): () -			Spouse:	
Chose Clinic Because/ Referred to Clinic By <input type="checkbox"/> Dr.: <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend							
<input type="checkbox"/> Former Patient <input type="checkbox"/> Close to Work/Home <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Street Sign <input type="checkbox"/> Other:							

WORK INFORMATION

Employer:			Work Phone () -		Ext.	
Occupation:		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Name of Secondary Insurance:					
Subscriber's Name:					Birth date: / /
ID. #:		Group/Policy #			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					

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

Insurance Name: <input type="checkbox"/> Auto :			<input type="checkbox"/> 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: MALE 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 / seizures
thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis
rheumatoid arthritis / hx of stroke / kidney problems / depression / osteoporosis / hx of blood clots/DVTs
Other: _____

Surgical History (list type & date): _____

Pelvic History (fill in blanks or circle answer for all that apply):

History of Benign Prostatic Hyperplasia? No OR Yes: (specify date(s) and any treatments received)

History of prostate cancer? No OR Yes: (specify date(s) and treatments) _____

History of hemorrhoids or other colorectal problems? No OR Yes: (specify date(s) and treatments)

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

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

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

MALE PELVIC HEALTH REHAB: SYMPTOM QUESTIONNAIRE

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

- Urgency (experiencing unusually strong urges to urinate that may come on suddenly)
- Frequency: urinate _____ 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 / hear running water / dribble after urination
other: _____
- Leaking: I leak _____ times a (circle one): day / week.
- Leaking: I cannot tell when I leak; sometimes it feels like I constantly leak.
- Use of leakage protection (number per day): thin 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 intake of each of the following per day:

- Water
- Soft Drinks
- Decaf Tea
- Alcohol
- Milk
- Decaf Soft Drinks
- Coffee
- Other: _____
- Juice (specify: _____)
- Tea
- Decaf Coffee

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

- Number of bowel movements per (circle one) day / week : _____
- Constipation: Do you 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
/ 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: _____
- How long has pain occurred: _____
- 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): _____



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 me 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



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; 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



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.

No Shows: 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.

Chronic Cancellations: 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).

Workers' Compensation and Personal Injury: 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.

Emergencies: 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