

PERRY PHYSICAL THERAPY, INC.

PATIENT REGISTRATION

Name _____ Date _____
Last First Mi

Address _____
Street City State Zip Code

Phone (w/area code) _____ Work Phone _____ Cell Phone _____

Social Security Number _____ Birth Date _____ E-mail Address _____

Sex: Female Male Marital Status: Single Married Divorced Widowed

Race: American Indian Asian Black Caucasian Other _____

Ethnicity: Hispanic Non-Hispanic Declined

Language: English Spanish Other _____

Employer _____ Occupation _____

Employer's Address _____ Your Primary Care Physician _____

Referring Physician _____ Date of your next visit _____

Name of person who should receive statement (other than patient) _____

Statement address (if different than patient's address) _____

Who should we contact in an emergency? _____ Phone Number _____

INSURANCE INFORMATION (PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR COPYING)

Primary Insurance _____

Insured's Name _____ Birth Date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Insured's Name _____ Birth Date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT (PLEASE COMPLETE THIS SECTION)

Date of accident How did it happen? Auto Work Other (location) _____

Involvement in Accident if Auto Driver Passenger Pedestrian Cyclist

Attorney's (Name/Address/Phone) _____

Insurance Company (worker's comp or your auto PIP) _____

Address _____ Phone Number _____

Claim Number _____ Adjuster _____ Name of Insured _____

Please tell us how you learned of our service or whom we can thank.

- | | | |
|---|--|--|
| <input type="checkbox"/> I was a Former Patient | <input type="checkbox"/> Former Patient recommendation | <input type="checkbox"/> Case Manager recommendation |
| <input type="checkbox"/> Doctor recommendation | <input type="checkbox"/> Family or Friend recommendation | <input type="checkbox"/> Yellow Page advertisement |
| <input type="checkbox"/> Insurance Company recommendation | <input type="checkbox"/> Employer recommendation | <input type="checkbox"/> Web page |
| <input type="checkbox"/> Health Club recommendation | <input type="checkbox"/> Newspaper advertisement | Name _____ |
| <input type="checkbox"/> Clinic Sign | <input type="checkbox"/> Billboard advertisement | Name _____ |
| <input type="checkbox"/> TV advertisement | <input type="checkbox"/> Radio advertisement | |

I learned about you another way. (please explain) _____

PATIENT SIGNATURE _____ Date _____

Patient History

Name _____ DOB _____ Age _____ Date _____

1. Describe the current problem that brought you here? _____

2. When did your problem first begin? _____

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

4. Since that time is it: staying the _____ same _____ getting worse _____ getting better
Why or how? _____

5. If pain is present rate pain on a 0-10 scale 10 being the worst. _____

6. Describe the nature of the pain (i.e. constant burning, intermittent ache) _____

7. Describe previous treatment/exercises _____

8. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

- | | |
|--|--|
| <input type="checkbox"/> Sitting greater than _____ minutes | <input type="checkbox"/> With cough/sneeze/straining |
| <input type="checkbox"/> Walking greater than _____ minutes | <input type="checkbox"/> With laughing/yelling |
| <input type="checkbox"/> Standing greater than _____ minutes | <input type="checkbox"/> With lifting/bending |
| <input type="checkbox"/> Changing positions (ie. - sit to stand) | <input type="checkbox"/> With cold weather |
| <input type="checkbox"/> Light activity (light housework) | <input type="checkbox"/> With triggers i.e. /key in door |
| <input type="checkbox"/> Vigorous activity/exercise (run/weight lift/jump) | <input type="checkbox"/> With nervousness/anxiety |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> No activity affects the problem |
| <input type="checkbox"/> Other, please list _____ | |

9. What relieves your symptoms? _____

10. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify _____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

11. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____

12. What are your treatment goals/concerns? _____

Since the onset of your current symptoms have you had:

- | | | | |
|-----|--------------------------------------|-----|-------------------------------|
| Y/N | Fever/Chills | Y/N | Malaise (unexplained tirednes |
| Y/N | Unexplained weight change | Y/N | Unexplained muscle weakness |
| Y/N | Dizziness or fainting | Y/N | Night pain/sweats |
| Y/N | Change in bowel or bladder functions | Y/N | Numbness / Tingling |
| Y/N | Other /describe _____ | | |

Date of Last Physical Exam _____ Tests performed _____

Pg 2 History Name _____ DOB ID# _____ Age _____

General Health: Excellent Good Average Fair Poor Occupation _____

Hours/week _____ On disability or leave? _____ Activity Restrictions? _____

Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week

Describe _____

Mental Health: Current level of stress High Med Low Current psych therapy? Y/N

Have you ever had any of the following conditions or diagnoses? Circle all that apply

- | | | |
|----------------------------|--------------------------|---------------------------------|
| Cancer | Stroke | Emphysema/chronic bronchitis |
| Heart problems | Epilepsy/seizures | Asthma |
| High Blood Pressure | Multiple sclerosis | Allergies-list below |
| Ankle swelling | Head Injury | Latex sensitivity |
| Anemia | Osteoporosis | Hypothyroid/ Hyperthyroid |
| Low back pain | Chronic Fatigue Syndrome | Headaches |
| Sacroiliac/Tailbone pain | Fibromyalgia | Diabetes |
| Alcoholism/Drug problem | Arthritic conditions | Kidney disease |
| Childhood bladder problems | Stress fracture | Irritable Bowel Syndrome |
| Depression | Acid Reflux /Belching | Hepatitis |
| Anorexia/bulimia | Joint Replacement | Sexually transmitted disease |
| Smoking history | Bone Fracture | Physical or Sexual abuse |
| Vision/eye problems | Sports Injuries | Raynaud's (cold hands and feet) |
| Hearing loss/problems | TMJ/ neck pain | Pelvic pain |
| Other/Describe _____ | | |

Surgical /Procedure History

- | | | | |
|----------------------|--------------------------------|-----|-----------------------------------|
| Y/N | Surgery for your back/spine | Y/N | Surgery for your bladder/prostate |
| Y/N | Surgery for your brain | Y/N | Surgery for your bones/joints |
| Y/N | Surgery for your female organs | Y/N | Surgery for your abdominal organs |
| Other/describe _____ | | | |

Ob/Gyn History (females only)

- | | | | |
|-----|---------------------------------|-----|-----------------------------|
| Y/N | Childbirth vaginal deliveries # | Y/N | Vaginal dryness |
| Y/N | Episiotomy # | Y/N | Painful periods |
| Y/N | C-Section # | Y/N | Menopause - when? _____ |
| Y/N | Difficult childbirth # | Y/N | Painful vaginal penetration |
| Y/N | Prolapse or organ falling out | Y/N | Pelvic/genital pain _____ |
| Y/N | Other /describe _____ | | |

Males only

- | | | | |
|-----|------------------------------------|-----|----------------------|
| Y/N | Prostate disorders | Y/N | Erectile dysfunction |
| Y/N | Shy bladder | Y/N | Painful ejaculation |
| Y/N | Pelvic/genital pain location _____ | | |
| Y/N | Other /describe _____ | | |

<u>Medications - pills, injection, patch</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Over the counter -vitamins etc</u>	<u>Start date</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pelvic Symptom Questionnaire

Bladder / Bowel Habits / Symptoms

Y/N	Trouble initiating urine stream	Y/N	Blood in stool/feces
Y/N	Urinary intermittent /slow stream	Y/N	Painful bowel movements (BM)
Y/N	Strain or push to empty bladder	Y/N	Trouble feeling bowel urge/fullness
Y/N	Difficulty stopping the urine stream	Y/N	Seepage/loss of BM without awareness
Y/N	Trouble emptying bladder completely	Y/N	Trouble controlling bowel urge
Y/N	Blood in urine	Y/N	Trouble holding back gas/feces
Y/N	Dribbling after urination	Y/N	Trouble emptying bowel completely
Y/N	Constant urine leakage	Y/N	Need to support/touch to complete BM
Y/N	Trouble feeling bladder urge/fullness	Y/N	Staining of underwear after BM
Y/N	Recurrent bladder infections	Y/N	Constipation/straining _____% of time
Y/N	Painful urination	Y/N	Current laxative use -type _____
Y/N	Other/describe _____		

Describe typical position for emptying: _____

1. Frequency of urination: awake hour's ___ times per day, sleep hours ___ times per night
 2. When you have a normal urge to urinate, how long can you delay before you have to go to the toilet? ___ minutes, ___ hours, _____ not at all
 3. The usual amount of urine passed is: ___ small ___ medium ___ large
 4. Frequency of bowel movements ___ times per day, _____ times per week, or _____.
 5. The bowel movements typically are: watery ___ loose ___ formed ___ pellets ___ other _____
 6. When you have an urge to have a bowel movement, how long can you delay before you have to go to the toilet? _____ minutes, _____ hours, _____ not at all.
 7. If constipation is present describe management techniques _____
 8. Average fluid intake (one glass is 8 oz or one cup) _____ glasses per day.
Of this total how many glasses are caffeinated? ___ glasses per day.
 9. Rate a feeling of organ "falling out" / prolapse or pelvic heaviness/pressure:
___ None present
___ Times per month (specify if related to activity or your menstrual period)
___ With standing for _____ minutes or _____ hours.
___ With exertion or straining
___ Other _____
- | | |
|---|--|
| <ol style="list-style-type: none"> 10a. Bladder leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with physical exertion/cough | <ol style="list-style-type: none"> 10b. Bowel leakage - number of episodes
___ No leakage
___ Times per day
___ Times per week
___ Times per month
___ Only with exertion/strong urge |
|---|--|
- 11a. On average, how much urine do you leak?
___ No leakage
___ Just a few drops
___ Wets underwear
___ Wets outerwear
___ Wets the floor
 - 11b. How much stool do you lose?
___ No leakage
___ Stool staining
___ Small amount in underwear
___ Complete emptying
___ Other _____
12. What form of protection do you wear? (Please complete only one)
___ None
___ Minimal protection (tissue paper/paper towel/pantishields)
___ Moderate protection (absorbent product, maxi pad)
___ Maximum protection (specialty product/diaper)
___ Other _____

On average, how many pad/protection changes are required in 24 hours? _____ # of pads

INFORMED CONSENT FOR PELVIC FLOOR MUSCLE EVALUATION

During the physical therapy evaluation for the problems you have reported, an assessment of your low back, hips, and pelvic girdle will be performed by a physical therapist in order to identify any musculoskeletal problems. This may include an evaluation of your pelvic floor muscles for strength, resting tone (tightness), and coordination (contract/relax). The findings will be discussed with you, and you will work with your physical therapist to develop a treatment plan that is appropriate for YOU. Your evaluation MAY include an internal assessment of the pelvic floor muscles, which could be completed vaginally (females) or rectally (males & females). A biofeedback assessment of your pelvic floor muscles may also be performed and may include internal or external sensors. Your physical therapist will discuss this option and receive your consent BEFORE initiating this exam. You absolutely can say NO, and your physical therapist can assess and treat the pelvic floor muscles externally (from the outside) if needed. The assessment of the pelvic floor muscles may result in soreness or discomfort temporarily. If this occurs, please discuss your symptoms with your physical therapist.

We realize that many patients may be apprehensive because of the private nature of the condition and the examination. Please ask as many questions as you need to increase your comfort and understanding of your evaluation, its findings, and treatment. Please discuss any concerns or hesitation that you may have with your physical therapist.

By signing this form, you agree and understand that treatment as indicated above may be necessary for effective treatment of your problem, and you agree that we have your permission to treat as discussed. You are always free to change your mind at any time during your course of treatment, and you are encouraged to notify your physical therapist of any changes of your preferences.

If you consent, you have the option to have a second person in the room for the pelvic floor muscle evaluation and treatment (as described above). The second person could be a friend, family member, or clinic staff member. Please indicate your preference with your initials:

_____ YES I want a second person present during the pelvic floor muscle evaluation and treatment.

_____ NO I do not want a second person during the pelvic floor muscle evaluation and treatment.

_____ I would like to discuss my options with my physical therapist prior to consenting.

24 Hour Cancellation Policy: Please provide 24 hour notice in order to reschedule or cancel your appointment. Cancellations with less than 12 hours notice, or no notice, will result in an automatic \$35 fee. If you arrive late for your appointment, the therapist may not have time to treat you, or your therapy time may be reduced. Please *initial* to indicate your understanding and agreement of the 24 Hour Cancellation Policy → _____

CONSENT

I have read and understand the Informed Consent for Pelvic Floor Muscle Evaluation, and I consent to the evaluation and treatment, unless otherwise noted below.

(Please list any exception to consent – if none, write none.)

Patient Name: _____

Signature: _____ Date: _____



**PERRY
PHYSICAL
THERAPY**

**Informed Consent for Physical Therapy Evaluation and Treatment
and Patient's Rights and Responsibilities**

Patient Name _____

Please initial each section to indicate your understanding and agreement.

____ Consent: I consent to and authorize Perry Physical Therapy, Inc. (including students in training) to administer physical therapy evaluation and treatment under the direction and supervision of the licensed physical therapist. The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation, and course of treatment. The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained the risks of receiving no treatment. I understand that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually, but not always, temporary; if it does not subside within a reasonable time frame (1-2 days), I agree to immediately inform my physical therapist and discuss possible solutions with him/her. My physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition or that my condition will not degenerate further; however, I should gain a greater knowledge about managing my condition and the resources available to me.

It is my right to decline any part of my treatment at any time before or during treatment, should I feel any pain or have any unresolved concerns. It is my right to ask the physical therapist about the treatment he/she has planned. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment.

In order for physical therapy treatment to be effective, I must come to scheduled appointments, unless there are unusual circumstances. I understand and agree to cooperate with and perform the physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

In the event of a change in medical status, I understand that my treatment may be modified, stopped, or referred out to the proper practitioner. I agree to inform my physical therapist about any health problems or allergies I have, as well as medications I am taking.

I have been given an opportunity to ask questions, and all of my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. I reserve the right to withdraw at any time. I understand the risks associated with a program of physical therapy as outlined to me, and I wish to proceed.

____ 24 hour Cancellation Policy: Please provide 24 hour notice in order to reschedule or cancel your appointment. Cancellations with less than 12 hours notice, or no notice, will result in an automatic \$35 fee. If you arrive late for your appointment, the therapist may not have time to treat you, or your therapy time may be reduced.

Signature of Patient/Responsible Party or Guardian: _____

Printed Name: _____ Date: _____

Relationship of signor to patient, if signed by person other than patient: _____



PERRY PHYSICAL THERAPY

HIPAA Privacy Policies/Release of Information

Perry Physical Therapy, Inc. releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in the HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits. I acknowledge I was offered a copy of Perry Physical Therapy's HIPAA Privacy Policies.

I do want to receive a copy of the privacy policy. _____
I do not want to receive a copy of the privacy policy. _____

Perry Physical Therapy, Inc. requires a written request for copies of your medical records. We also require a written authorization by the patient or responsible adult to release medical records. There is a \$25 fee for making copies and sending them to the requestor. This fee is paid by the requestor, but never the patient. We will try to expedite the processing of the request; however, we have 30 days to comply with any request for copies of your medical records.

Perry Physical Therapy, Inc. has permission to RELEASE or DISCUSS any medical information to the following. (Check any or all that you approve.)

My Spouse _____ My Parent _____ My Child _____ Other _____

Perry Physical Therapy, Inc. has permission to leave a message on my answering machine/voicemail for the following reasons: (check any or all that you approve)

Appointment date and time or Missed Appointments _____ Billing Issues/Balance _____

Your Health Information Rights

You have certain rights under federal privacy standards. These include:

- *The rights to request restrictions on the use and disclosure of your health information.
- *The right to receive confidential communications concerning your medical condition and treatment.
- *The right to inspect and copy your health information.
- *The right to amend and/or submit corrections to your health information.
- *The right to receive any accounting of how and to whom your health information had been disclosed.
- *The right to receive any printed copy of this notice.

Complaints

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the company by sending a letter outlining your concerns to:

Privacy Officer, Stacey Matthews
Perry Physical Therapy, Inc.
3737 Britton Rd.
Perry, MI 48872

Signature of Patient/Responsible Party or Guardian: _____
Printed Name: _____ Date: _____
Relationship of signor to patient, if signed by person other than patient: _____



**PERRY
PHYSICAL
THERAPY**

Financial Policy

Perry Physical Therapy, Inc. is committed to providing excellent care for you. We participate with most major and minor insurance plans. If you are unsure if we take your insurance plan or not, please call us to verify. By signing this policy you will authorize Perry Physical Therapy, Inc. to receive reimbursement from your plan, to provide any requested information your insurance plan requires for claims review, claims audit, and/or claims payment. By signing this policy, you will also agree to this payment policy.

Payment: It is our policy to collect all patient past due balances, deductibles, copays, and master medical balances at the time of service. It is the patient's responsibility to know his/her insurance benefits. Perry Physical Therapy, Inc. will call your insurance company to verify benefits as a courtesy to you. We accept cash, check, Visa, MasterCard, Discover, American Express, and debit cards.

Cancellation/No Show: When a patient cancels without giving enough notice, they prevent another patient from being seen. If prior notification of cancellation is not given, you will be charged a \$35 fee for a standard appointment or a \$50 fee for new patient visits or pelvic floor rehab appointments. This charge will not be billed to your insurance company; it will be billed to you directly.

Insurance: We do file most insurance claims, but require current and accurate information. If your insurance has updated, we require you to bring in your updated information for us to put on file. If we do not have current and accurate insurance information at each visit you will be required to pay for services in full on that date and until that information is updated in our system. We recommend you contact your insurance company to confirm we are in network with them, so that you can receive the highest benefit possible. Copays, coinsurance, and deductibles are the responsibility of the patient and are to be paid at each visit by the patient, responsible party or, in the case of a minor, by the adult bringing the child in for treatment.

Billing Statements: Billing statements are mailed monthly for any balances due. Service dates still pending with insurance are not billed to you until insurance has responded. Payment is due upon receipt of the monthly billing statement. If you are unable to pay the full balance at the time of receipt, please contact the office immediately to make arrangements for an alternative payment schedule. Balances not paid and reaching beyond 90 days are reviewed and may be referred to an outside collections agency which could report the outstanding balance to a credit bureau.

_____ Date of Birth: _____
Printed name of patient

_____ Date: _____
Signature of patient (or representative)