PERRY
PHYSICAL
THERAPY

Your appointment is:_____ at _____ am/pm with_____

To assist us with expediting your check-in, please arrive **15 minutes** prior to your appointment time. Also, we have enclosed our Patient Registration sheet to be completed and handed in when you check in.

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

Perry Physical Therapy is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. If prior notification of cancellation is not given, you may 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. Perry Physical Therapy office hours are Monday-Friday 7:00 am to 6:00 pm. **Please call us at (517) 625-0772 by 3:00 pm on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00 pm on Friday.**

Please bring your insurance card(s), photo ID, prescription from referring doctor, and this packet completely filled out.

If this packet is not completely filled out at the time of your scheduled appointment, you may be asked to reschedule.

Thank you for choosing Perry Physical Therapy

3737 Britton Rd • Perry, MI 48872 • 517-625-0772 • Fax 517-625-0778

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.

☐ I was a Former Patient
☐ Doctor recommendation
☐ Insurance Company recommendation
☐ Health Club recommendation
☐ Clinic Sign
☐ TV advertisement
☐ Former Patient recommendation
☐ Family or Friend recommendation
☐ Employer recommendation
☐ Newspaper advertisement
☐ Billboard advertisement
☐ Radio advertisement
☐ Case Manager recommendation
☐ Yellow Page advertisement
☐ Web page
Name _____
Name _____

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

__ Sitting greater than_____ minutes	__ With cough/sneeze/straining
__ Walking greater than _____minutes	__ With laughing/yelling
__ Standing greater than _____ minutes	__ With lifting/bending
__ Changing positions (ie. - sit to stand)	__ With cold weather
__ Light activity (light housework)	__ With triggers i.e. /key in door
__ Vigorous activity/exercise (run/weight lift/jump)	__ With nervousness/anxiety
__ Sexual activity	__ No activity affects the problem

__ 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 tiredness)
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_____
_____

Kathe Wallace
PHYSICAL THERAPY

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	Pregnancies #____	Y/N	Vaginal dryness
Y/N	Deliveries #____	Y/N	Painful periods
	Type of Delivery: vaginal #__ 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)_____		

Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -vitamins etc	Start date	Reason for taking

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 _____		

1. Frequency of urination: while awake ____ times per day, during sleep waking _____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 or _____times per week.
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_____

10a. Bladder leakage - number of episodes	10b. Bowel leakage - number of episodes
__ No leakage	__ No leakage
__ Times per day	__ Times per day
__ Times per week	__ Times per week
__ Times per month	__ Times per month
__ Only with physical exertion/cough	__ Only with exertion/strong urge

11a. On average, how much urine do you leak?	11b. How much stool do you lose?
__ No leakage	__ No leakage
__ Just a few drops	__ Stool staining
__ Wets underwear	__ Small amount in underwear
__ Wets outerwear	__ Complete emptying
__ Wets the floor	__ 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

Kathe Wallace
PHYSICAL THERAPY

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 treament. 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 with 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:_____

3737 Britton Rd · Perry, MI 48872 · 517-625-0772 · Fax 517-625-0778

PERRY
PHYSICAL
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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 HIPPA 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)

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