



## Pelvic Floor Therapy Intake

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Sex: F / M Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Are you Active Duty? Yes / No

### History of Symptoms

**a.** Why are you seeking care from a Pelvic Floor Therapist? Please list current symptoms:

\_\_\_\_\_

**b.** Date of Symptom Onset: \_\_\_\_\_ If surgery, what did you have done?

\_\_\_\_\_

**c.** Have you received Therapy for this problem before? \_\_\_\_\_ If yes, when and where?

\_\_\_\_\_

**d.** In the last 30 days, have you received services from a hospital, nursing home, or home health agency? If yes, when? Who?

\_\_\_\_\_

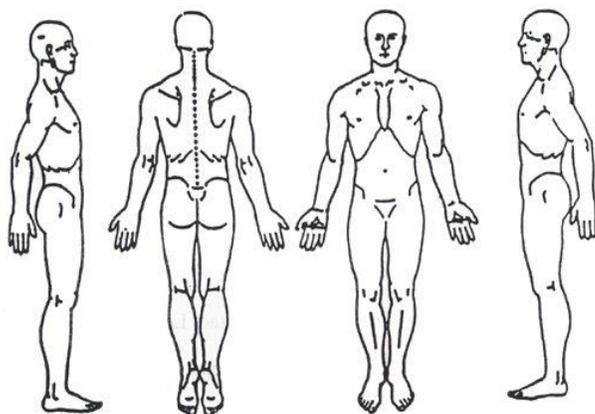
**e.** Have you had any imaging for this problem? If yes, complete below:

| Diagnostic Image | Date Received | Results |
|------------------|---------------|---------|
| X-Ray            |               |         |
| MRI              |               |         |
| CT Scan          |               |         |

**f.** Please rate your pain on the scale below (Zero = No Pain, 10 = Severe Pain):

|                      |                        |
|----------------------|------------------------|
| Pain at <b>BEST</b>  | 0 1 2 3 4 5 6 7 8 9 10 |
| Pain at <b>WORST</b> | 0 1 2 3 4 5 6 7 8 9 10 |

**g.** Please circle the location of your pain on the chart below:



**Circle the word(s) that describe the quality of your pain:**

- Aching
- Numbness
- Pins & Needles
- Burning
- Stabbing
- Dull

Other: \_\_\_\_\_

**h.** Are you currently on limited duty status? Are you going through a MedBoard process?

\_\_\_\_\_

Patient Name: \_\_\_\_\_

| Medical History   |                                   |   |                                   |
|---|-----------------------------------|---|-----------------------------------|
| <b>a. Please list all medications you are currently taking (Required):</b>  |                                   |   |                                   |
| Medication Name   | Frequency                         | Dosage  |                                   |
|   |                                   |   |                                   |
|   |                                   |   |                                   |
|   |                                   |   |                                   |
|   |                                   |   |                                   |
| <b>b. Please mark all that apply to you currently or in the past:</b>   |                                   |   |                                   |
| <input type="checkbox"/>  | Incontinence: Urinary or fecal    | <input type="checkbox"/>                                      | STD/STI                           |
| <input type="checkbox"/>  | History of physical/sexual abuse  | <input type="checkbox"/>                                      | PTSD                              |
| <input type="checkbox"/>  | UTIs, bacterial vaginosis         | <input type="checkbox"/>                                      | Balance Issues/Dizzy spells       |
| <input type="checkbox"/>  | High blood pressure/Heart Disease | <input type="checkbox"/>                                      | Smoker                            |
| <input type="checkbox"/>  | Kidney problems                   | <input type="checkbox"/>                                      | Metal implants/Pacemaker          |
| <input type="checkbox"/>  | Nervous disorder                  | <input type="checkbox"/>                                      | Seizures                          |
| <input type="checkbox"/>  | Asthma                            | <input type="checkbox"/>                                      | Ulcers/ stomach problems/IBS      |
| <input type="checkbox"/>  | Low back pain                     | <input type="checkbox"/>                                      | Fibromyalgia                      |
| <input type="checkbox"/>  |                                   | <input type="checkbox"/>                                      | HIV                               |
| <input type="checkbox"/>  |                                   | <input type="checkbox"/>                                      | Vision problems                   |
| <input type="checkbox"/>  |                                   | <input type="checkbox"/>                                      | Diabetes                          |
| <input type="checkbox"/>  |                                   | <input type="checkbox"/>                                      | Headaches                         |
| <input type="checkbox"/>  |                                   | <input type="checkbox"/>                                      | Hearing problems                  |
| <input type="checkbox"/>  |                                   | <input type="checkbox"/>                                      | Arthritis                         |
| <input type="checkbox"/>  |                                   | <input type="checkbox"/>                                      | Cancer                            |
| <input type="checkbox"/>  |                                   | <input type="checkbox"/>                                      | Anxiety/Depression                |
| <b>c. Obstetric History: Please include numbers/dates as appropriate</b>  |                                   |   |                                   |
| Live births:  |                                   | Vaginal deliveries:   | Episiotomy/perineal tearing:      |
| C-sections:   |                                   | Miscarriages:   | Abortions/D&C:                    |
| Total number of pregnancies:  |                                   | Currently pregnant:   | Currently trying to get pregnant: |
| Menopause/post-menopausal:  |                                   | Hormone replacement therapy:                                  | Painful intercourse:              |
| <b>d. Additional surgical history (heart, joint replacement, etc.):</b>   |                                   |   |                                   |
| Surgery:  |                                   | Date:   |                                   |
| Surgery:  |                                   | Date:   |                                   |
| Surgery:  |                                   | Date:   |                                   |
| <b>e. Bladder Habits – Do you experience...?</b>  |                                   |   |                                   |
| Loss of urine beyond your control?  |                                   | Frequent or urgency urination?                                |                                   |
| Use a continence product or pad?  |                                   | How many pads/day?  |                                   |
| <b>f. Bowel Habits –</b>  |                                   |   |                                   |
| How often do you have a bowel movement?   |                                   | What is the consistency of your BM? Hard, soft, liquid.       |                                   |
| Do you experience pain or straining to have a BM?   |                                   | Do you take anything to help BM? (Stool softener, fiber, etc) |                                   |
| <b>g. Is there anything else you would like your Therapist to know about your pelvic health, urinary/bowel, or sexual function?</b> |                                   |   |                                   |
|   |                                   |   |                                   |

**The above information is correct to the best of my knowledge.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physical/Occupational Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physical/Occupational Therapist Printed Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

## Patient Information Consent: HIPAA Release

I have read and fully understand Rehab United's Notice of Information Practices. I understand that Rehab United may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Rehab United will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Rehab United's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

## Patient Responsibilities

- 1. Check in/Sign-in for each visit:** Please check in with the front office at every visit. You will need to sign in with the appropriate date and time.
- 2. Payment is due at the time of service:** Deductibles, co-insurances, co-payments & wellness payments are due at the time of your appointment. RU urges you to place a credit card on file for automatic payments at the time of your appointment.
- 3. Update your information with the front office:** Please inform the front office of any changes to your insurance and/or personal information. This is imperative to ensure all claims are processed correctly and in a timely manner.
- 4. Scheduling appointments:** Appointment availability is on a first-come, first-served basis. Please work with the front office to schedule your future appointments as far in advance as possible to ensure you secure your preferred times. \*Please note that the front office does not schedule visits without the patient or guardian requesting an appointment slot. Appointments are not reserved for "normal" schedules.
- 5. Personal belongings:** RU provides small storage space (with no locking feature) for your car keys and smaller items, but does not have the space for other personal belongings. You assume the liability for the safety of your personal items.
- 6. Check out with the front office staff after each visit:** Please check out with the front office after every visit. The front office will confirm your next appointment and assist in scheduling future appointments at this time.

## Cancellation & No-Show Policy

We are sincerely dedicated in assisting you in meeting your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program, which will result in quicker recovery and better outcomes.

If it is necessary to cancel or re-schedule your appointment, we require that you notify us at least 24 hours in advance. Appointments are in high demand, which is why Rehab United follows a strict cancellation policy, and your early cancellation will allow the time to be reallocated to another patient who will benefit from the treatment.

When a patient is late the entire schedule is affected. Therefore, we politely ask that our patients be prompt in being present at the time of their scheduled appointments. **We reserve the right to reappoint patients arriving 15 minutes after their scheduled appointment time.**

**\*\*Late Cancellations:** A cancellation is considered to be late when the appointment is cancelled without a 24-hour advance notice. A **Cancellation fee of \$50.00** will be charged to the patient.

- Cancellation Fee may be waived if the canceled appointment is rescheduled and attended within the same week.
  - If the Late Cancellation is scheduled for a Friday, there is no option to reschedule and have the fee waived.

**\*\*No Show Policy:** A "no-show", is a patient who misses or doesn't show for an appointment without cancelling it. A **No-Show Fee of \$60.00** will be charged to the patient. **These fees are not covered by your insurance.**

Patient Name: \_\_\_\_\_

*\*\*Fees will not be assessed to patients insured by TriWest Healthcare Alliance/Department of Veterans Affairs.*

*Helpful Hints to Avoid Fees:*

- Ask the front office to activate either an email or text appointment reminder notification.
- Check out with the front desk after every visit to confirm your next appointment.
- Request a printout of your scheduled visits from the front desk and retain this for your reference. This print out is what Rehab United has in their schedule and is the system to which we follow for all appointment times.
- If you need to cancel, call Rehab United and speak to a front office representative or leave a message if after hours.
- The front office is responsible for all therapists' schedules, so always inform the front office of cancellations or needs to re-schedule. **\*\*Telling/calling a therapist and/or aide is not acceptable notice.**

**I have read and understand the above policies.** By signing below, the patient and/or guardian hereby acknowledge and certify that he/she has read and understand the information outlined above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Photo and Video Release (Optional)**

I hereby authorize Rehab United Sports Medicine and Physical Therapy and Fit Societe to use my testimonial, photos, videos, audio and any information contained herein in its media, public relations, marketing, social media, and educational efforts. I understand and approve the disclosure of the testimonial, photo, video, or audio information to the media and other individuals and entities that may be involved in these efforts for Rehab United Sports Medicine and Physical Therapy and Fit Societe.

I authorize Rehab United Sports Medicine and Physical Therapy and Fit Societe to disclose limited information about my condition or treatment for these purposes, and understand that no other protected information will be disclosed publicly, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release Rehab United Sports Medicine and Physical Therapy and Fit Societe from any and all claims for damages of any kind based on the use of my testimonial, picture, video, audio or information in the testimonial. By signing below, I agree and acknowledge that I have read and understood the above Release and agree to all terms described.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### Credit Card Authorization (Optional)

**Deductibles, Copays, and Co-Insurances are due IN FULL at the time of service.** At the beginning of treatment, we request you secure your account with a credit card. This card will only be charged with your permission (indicated by your selection below). We offer two options for charging the patient responsibility relating to your treatment. As a courtesy to you, we can automatically charge your card the estimated patient responsibility for each visit based on the quoted benefits from your insurance company throughout your treatment. Once your claims have been processed, the Explanation of Benefits from your insurance company will determine the patient responsibility and any necessary changes to the amount due will be made. Additionally, we will use the credit card to process any cancellation or no-show fees that you have incurred (FSA/HSA Cards will not be charged cancellation and/or no-show fees). A receipt will be provided for any charges processed by Rehab United, at your request. If you prefer to bring in payment at every appointment, we will use your credit card on a monthly basis to charge any remaining fees owed once claims have processed by your insurance company and/or any missed payments for services already provided.

| Credit Card Information   |   |                                     |  |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover <input type="checkbox"/> American Express <input type="checkbox"/> FSA <input type="checkbox"/> HSA |   |                                     |  |
| Name on Card:   |   |                                     |  |
| Card Number:  |   |                                     |  |
| Expiration Date:  |   | Security Code:                      |  |
| Billing Address:  |   |                                     |  |
| Amount to Be Charged:   |   | Do You Require an Itemized Receipt? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Please Initial the Option You Prefer  |   |                                     |  |
|   | <b>CHARGE AT TIME OF SERVICE:</b> I agree to allow Rehab United to charge my credit card on file for the amount due at each appointment and for any remaining balance I owe.                |                                     |  |
|   | <b>CHARGE BALANCE OWED:</b> I will pay the estimated amount due per session at each appointment and will have my credit card on file available <b>only</b> for any remaining balance I owe. |                                     |  |

I require notification for any charge larger than \$\_\_\_\_\_       I don't require notification.

I have read this Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Rehab United Sports Medicine and Physical Therapy, Inc. Furthermore, I agree to assign all health insurance benefits directly to Rehab United Sports Medicine and Physical Therapy, Inc. and understand that I am responsible for any costs not covered by my health insurance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_