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New Patient Information

Date_____

Name (First)_____ (Last)_____ (M.I.) _____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Other Phone_____

Social Security # _____ Date of Birth_____ Age _____ Sex: M / F

Drivers Lic #_____ Email Address_____

Primary Insurance Subscriber (If different from above):

Name (First)_____ (Last)_____

Social Security # _____ Date of Birth_____

Status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Emergency Contact_____ Telephone_____

Referring Physician_____Telephone_____

Address _____

[FOR OFFICE USE:NPI # _____]

Who may we thank for your referral other than your Doctor? _____

Employer_____ **Employment** Full / Part-time / Not Working / Retired

Address_____ Phone_____

Injury Type □ Work □ Auto □ Home □ Other_____ Injury Date_____

Lawyer Involved Yes / No Attorney name _____ **Referring**

Address_____ Telephone_____

_____ _____

Patient's signature Date

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Patient Name_____ Referring Physician_____ Age_____

Pain / Complaint_____ Date of Injury_____

If pregnant, # weeks of gestation_____

Anticipated or actual delivery date_____

# of Previous Pregnancies_____ # of C-Sections_____

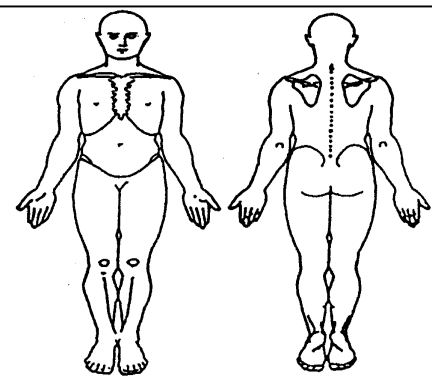
# of Vaginal Deliveries_____ # of Episiotomies_____

Next doctor's appointment? _____

Any complications during this or previous pregnancy? _____

Any complications during labor and delivery?_____

Postpartum weeks_____ Date of birth of last child_____



Please mark areas of concern

Have you recently noticed?

☐ Unusual Weight Loss /Gain
☐ Weakness
☐ Dizziness
☐ Headache
☐ Pain at Night
☐ Abdominal cramps
☐ Naval pain
☐ Low Back Pain
☐ Swelling
☐ Loss of Hair
☐ Persistent Nausea or Vomiting
☐ Fever / Chills / Sweats / Hot Flashes
☐ Numbness or tingling in hands, fingers or legs
☐ Restless Leg Syndrome
☐ Change in Sexual Function / Pain
☐ Insomnia
☐ Skin Irritation / Itchiness
☐ Cramps in Legs at Night / When Walking
☐ Pain with Rolling Over in Bed / Stairs
☐ Fatigue □ Hip Pain □ Constipation

Do you have now or have you ever had any of the following?

☐ Sprains/Strains, Fractures
☐ Multiple Gestation Pregnancy
☐ Allergies / Skin Sensitivity
☐ Circulation Problems / Clots
☐ Asthma / Breathing Problems
☐ Indigestion / Heartburn
☐ Sexually Transmitted Diseases
☐ Sciatica
☐ Diabetes
☐ Cancer
☐ Bleeding
☐ Fibroids
☐ Fainting
☐ Vaginal Infection
☐ Placentia Previa
☐ Blood Pressure Problems
☐ Incompetent Cervix
☐ Lung Disease
☐ Urinary Incontinence
☐ Pelvic Pain
☐ Endometriosis
☐ Thyroid Disorder
☐ Cystitis
☐ Heart Problems
☐ Kidney Disease
☐ Bowel Problems

Do you ever experience leakage of: Urine / Feces / Both / None

Do you have leakage with:

Coughing or sneezing? Y / N Exercise? Y / N

Before you can make it to the restroom? Y / N Unrelated to any cause? Y / N

Explain & give approximate dates for any items indicated above _____

_____

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Previous Surgeries

Hysterectomy: _____ abdominal / vaginal / ovaries removed
Hernia Repair: _____ C-Section: _____ Other: _____

Are you currently taking any medication? _____

Type Of Symptoms: Sharp / Burning / Aching / Tingling / Numbness / Other

Constant / Intermittent

Rate your symptoms (0= none, 10= severe)

At worst: 0 1 2 3 4 5 6 7 8 9 10 At best: 0 1 2 3 4 5 6 7 8 9 10

List 3 important activities that you are unable to do or are having difficulty with as a result of your problem. Then rate the activity in difficulty using the following scale:

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform perform activity at the same activity level as before injury

Activity 1: _____ Rate:_____
Activity 2: _____ Rate:_____
Activity 3: _____ Rate:_____

Is there anything else you would like to include or ask your therapist _____
_____

Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone? Yes / No

Within the last year, has anyone forced you to have sexual activities? Yes / No

Please rate the following. 0 – no, not at all, 1 – no, not very often, 2 – yes, most of the time, 3 – yes, all of the time:

I have blamed myself unnecessarily when things go wrong _____

I have been anxious or worried for no good reason _____

I have felt scared or panicky for no good reason _____

Patient's signature	Patient's name	Date

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Notice of Privacy Practices

(Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSES OF YOUR MEDICAL INFORMATION

For Treatment: We may use medical information about you to provide you with medical treatment or services. **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. **For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. **For Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. **For Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law. **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **For Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. **For Worker's Compensation:** We may release medical information about you for workers' compensation or similar programs. **For Public Health Risks:** We may disclose medical information about you for public health activities. **For Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. **For Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order.

For Law Enforcement: We may release medical information if asked to do so by law enforcement officials. **For Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. **For National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. **For Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. **For Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

YOUR RIGHT TO INSPECT AND COPY: To inspect and copy of your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed. **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request. **Your Right to an Accounting of Disclosures:** You have the right to request in writing, a list accounting for any disclosures of your medical information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. **We are not required to agree to your request. Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location. **Your Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice at any time.

CHANGES TO THIS NOTICE: We reserve the right to change this notice, and will post the current notice in our facility. **COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.

Patient's or personal representative's signature	Patient's or personal representative's name	Date

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Our policies

We are a small practice with a big mission, so our policies help us offer the best care to our clients on an ongoing basis. If you have any questions or concerns, please let us know.

CANCELLATION & NO-SHOW POLICY

Due to high demand and limited availability of appointments, we require notice in the event of a cancellation **before 5pm the day before your appointment**. The charge for cancellation without proper notice is $40 for physical therapy visits and/or the full price of a cash-pay massage or Pilates visit. This charge will not be covered by insurance, but will have to be paid by you personally PRIOR to receiving additional treatment.

Please enter a valid credit or debit card to be kept on file in the event of a Late Cancel/No Show to pay for your late cancellation or no show fee:

Name on card	Credit card number	Expiration date	CVV

I hereby authorize Evolution Physical Therapy charge my credit/debit card to cover acquired Late Cancel or No Show fee.

Signature of Card Holder

FINANCIAL POLICY

We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary you will be responsible for additional costs incurred.

Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. In the event that your continued treatment with us exceeds the coverage of your insurance policy, you will be responsible for the full cash payment of services rendered. We will do everything possible in order to obtain additional visits necessary once insurance coverage ceases (including steps necessary to appeal a denial); however, this does not guarantee that your insurance will accept the request to authorize additional visits. You are also responsible for keeping track of visits covered in your policy. If your insurance authorizes a request for additional visits beyond the initial visits covered in your policy, there will be no change from your financial responsibility outlined in your original policy.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

Patient / Responsible Party Signature	Patient / Responsible Party Name	Date

PARENTAL CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize Evolution Physical Therapy, Inc to treat the minor patient named in the attached forms while I am not present.

Parent / Guardian Signature	Parent / Guardian Name	Date

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Our policies (continued)

CONSENT FOR CARE & TREATMENT

Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for Evolution Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Evolution Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS

If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you

Patient's signature	Patient's name	Date

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Informed Consent For Assessment of Pelvic Floor Dysfunctions

I understand that if I undertake physical therapy for any pelvic floor dysfunction, it will be beneficial and necessary for my therapist to perform a muscle assessment of the pelvic floor to assess muscle strength, length, range of motion and scar mobility. Palpation of these muscles is most direct and accessible if done via the vagina and/or anal/rectal canal. Pelvic floor dysfunctions include but are not limited to pelvic pain syndromes, urinary incontinence, fecal incontinence, dyspareunia or pain with intercourse, pain from an episiotomy or scarring, vulvodynia, vestibulitis, constipation, pain with urination or defecation, diffuse gluteal pain, organ prolapse, diffuse lower extremity pain, other similar complications. Evaluation of my condition may include observation, direct muscle palpation, soft tissue mobilization, use of vaginal weights, dilators, vaginal or rectal sensors for biofeedback and/or electrical stimulation.

The benefits and risks of the vaginal/rectal assessment have been explained to me. I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

Treatment procedures for pelvic floor dysfunctions include, without limitation, education, exercise, neuromuscular reeducation using biofeedback, neuromuscular reeducation, electrical stimulation, ultrasound, use of vaginal weights and several manual techniques including massage, myofascial release, strain counter-strain, ischemic pressure, joint and soft tissue mobilization. Manual therapy techniques may need to be done internally via the vagina and/or anal/rectal canal. The therapist will explain all these treatment procedures to me and I may choose not to participate with all or part of the treatment plan.

Risks/side effects may include: muscle or joint soreness, slight muscle pain, referred discomfort to another part of the body, fatigue, temporary discomfort with defecation, walking or activities of daily living. Although, extremely unlikely/rare any pelvic exam may increase one's chance of urinary tract infection. I understand that no guarantees have been or can be provided to me regarding the success of therapy.

I have read the foregoing and any questions that I have asked have been answered to my satisfaction. I understand the risks, benefits and alternatives of the different treatment procedures.

I hereby voluntarily agree to allow my physical therapist to perform both initial and periodic muscle assessments of the pelvic floor via the vagina or anal/rectal canal and to perform muscular treatment techniques of the pelvic floor and perineal area.

Patient's signature	Patient's name	Date

PLEASE NOTE: Please inform the therapist prior to the pelvic floor assessment if you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post surgery, have severe pelvic pain, or have sensitivity to KY Jelly/vaginal creams or latex.