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Life changing physical therapy

Welcome to Pelvic Therapy Specialists, PC

So that your first visit and evaluation may be as efficient and productive as possible, following are some forms that we ask you to fill out before your appointment.

Completed forms allow for more treatment time in your first visit and less time spent on administrative items. More importantly, patients typically remember additional pertinent facts concerning their medical history when pre-evaluation forms are completed in the comfort of their homes.

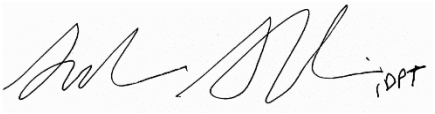
Following you will find:

Pre-Evaluation Questionnaire
Billing Information and Financial Policy
Informed Consent for Treatment of Pelvic Floor
Cancellation and No Show Policy
HIPPA Privacy Notice

Thank you for choosing Pelvic Therapy Specialists for your physical therapy care.

We look forward to working with you.

Sincerely,



Sandra Shevlin, DPT

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Fax 888.433.8309

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PRE-EVALUATION QUESTIONNAIRE:

Please remember to bring in completed forms to your first appointment.

Name _____

Address _____ City/State/Zip _____

Home Ph _____ Cell Ph_____ Email _____

Age _____ Date of Birth _____ Employer Name _____

Emergency Contact Name and Ph Number

_____

Referring Provider Name:_____

Address _____ City/State/Zip _____

Work Ph_____ Fax _____

If no referring provider, how did you hear about us? Facebook / Google / Yahoo / Friend-Family / Workshop-Class / Other: (please state) _____

Primary Care Provider Name:_____

Address _____ City/State/Zip _____

Work Ph_____ Fax _____

Reason for your visit: _____

_____

Goals of therapy:

_____

_____

Please List your Primary Complaints:

1.
2.
3.
4.

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PEDIATRIC HEALTH HISTORY AND SCREENING QUESTIONNAIRE

Patient History and Symptoms

Your answers to the following questions will help us to manage your child's care better. Please complete all pages **prior to** your child's appointment.

Name of parent or guardian completing this form_____

Child's name:_____Prefers to be called _____ Date: _____

Age _____Grade_____Height _____Weight_____

Describe the reason for your child's appointment_____

When did this problem begin? _____Is it getting better_____worse_____staying the same _____

Name and date of child's last doctor visit _____ Date of last urinalysis_____

Previous tests for the condition for which your child is coming to therapy. Please list tests and results_____

_____

_____

_____

Medications	Start date	Reason for taking
_____	_____	_____
_____	_____	_____

Has your child stopped or been unable to do certain activities because of their condition? For example, embarrassed to play with friends, can't go on sleepovers, feels ashamed about leakage and avoids play dates. _

_____

_____

Does your child now have or had a history of the following? Explain all "yes" responses below.

Y/N Pelvic pain
Y/N Low back pain
Y/N Diabetes
Y/N Latex sensitivity/allergy
Y/N Allergies
Y/N Asthma
Y/N Surgeries
Y/N Blood in urine
Y/N Kidney infections
Y/N Bladder infections
Y/N Vesicoureteral reflux Grade ____
Y/N Neurologic (brain, nerve) problems
Y/N Physical or sexual abuse
Y/N Other (please list)_____

Explain yes responses and include dates_____

Does your child need to be catheterized? Y/N If yes, how often? _____

Bladder Habits

1. How often does your child urinate during the day? _____times per day, every _____ hours.
2. How often does your child wake up to urinate after going to bed? _____times
3. Does your child awaken wet in the morning? Y/N If yes, _____ days per week.
4. Does your child have the sensation (urge feeling) that they need to go to the toilet? Y/N
5. How long does your child delay going to the toilet once he/she needs to urinate? (Circle one)
   - ___ Not at all
   - ___ 1-2 minutes
   - ___ 3-10 minutes
   - ___ 11-30 minutes
   - ___ 31-60 minutes
   - ___ Hours
6. Does your child take time to go to the toilet and empty their bladder? Y/N
7. Does your child have difficulty initiating the urine stream? Y/N
8. Does your child strain to pass urine? Y/N
9. Does your child have a slow, stop/start or hesitant urinary stream? Y/N
10. Is the volume of urine passed usually: Large Average Small Very small (circle one)
11. Does your child have the feeling their bladder is still full after urinating? Y/N
12. Does your child have any dribbling after urination; i.e. once they stand up from the toilet? Y/N

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13. Fluid intake (one glass is 8 oz or one cup)
    ___ of glasses per day (all types of fluid)
    ___ of caffeinated glasses per day
    Typical types of drinks _____
14. Does your child have "triggers" that make him/her feel like he/she can't wait to go to the toilet? (i.e. running water, etc.) Y/N please list_____

Bowel Habits

15. Frequency of movements: ___ per day __ per week. Consistency: loose__ normal___ hard__
16. Does your child currently strain to go? Y/N_____ Ignore the urge to defecate? Y/N_____
17. Does your child have fecal staining on his/her underwear? Y/N How often?_____
18. Does your child have a history of constipation? Y/N_____How long has it been a problem?_

SYMPTOM QUESTIONNAIRE

1. Bladder leakage (check all that apply)
    ___ Never
    ___ When playing
    ___ While watching TV or video games
    ___ With strong cough/sneeze/physical exercise
    ___ With a strong urge to go
    ___ Nighttime sleep wetting
2. Frequency of urinary leakage-number (#) of episodes
    ___ # per month
    ___ # per week
    ___ # per day
    ___ Constant leakage
3. Severity of leakage (circle one)
    ___ No leakage
    ___ Few drops
    ___ Wets underwear
    ___ Wets outer clothing
4. Bowel leakage (check all that apply)
    ___ Never
    ___ When playing
    ___ While watching TV or video games
    ___ With strong cough/sneeze/physical exercise
    ___ With a strong urge to go
5. Frequency of bowel leakage-number (#) of episodes
    ___ # per month
    ___ # per week
    ___ # per day
6. Severity of leakage (circle one)
    ___ No leakage
    ___ Stool staining
    ___ Small amount in underwear
    ___ Complete emptying
7. Protection worn (circle all that apply)
    ___ None
    ___ Tissue paper / paper towel
    ___ Diaper
    ___ Pull-ups
8. Ask your child to rate his/her feelings as to the severity of this problem from 0-10
    0_____10
    Not a problem Major problem
9. Rate the following statement as it applies to your child's life today
    My child's bladder is controlling his/her life.
    0_____10
    Not true at all Completely

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INSURANCE BILLING INFORMATION AND FINANCIAL POLICY

Patients are responsible for checking their insurance benefits including deductibles, co-pays, and/or co-insurance.

Pelvic Therapy Specialists' contract with your insurance carrier requires that we collect all co-payments at the time of service.

Insurance Filing Process:

When using your insurance plan to pay for physical therapy services, we will file the claim to your insurance carrier. Both Pelvic Therapy Specialists and you will subsequently receive an ***Explanation of Benefits*** in the mail from the insurance company – note this is not a bill.

If there is a remaining balance owed for deductibles and/or co-insurance, Pelvic Therapy Specialists will automatically bill you.

In order to allow this process to run smoothly, a copy of your Health Savings Card or Credit Card is required at your first appointment. Information will be kept offsite and secure in accordance with credit card industry regulations.

Payment Options:

Is the card you are furnishing a Health Savings Account? Yes / No

Is the card you are furnishing a Credit Card? Yes / No

Additional Information:

If you are furnishing a Health Savings Account card, does your Health Savings Account pay the physician directly before you are responsible?

YES NO UNKNOWN

Please circle the method you would like to receive a bill and a receipt.

EMAIL FAX PICK UP DON'T SEND

If requesting the bill and receipt via email or fax, please enter information below (please write legibly)

_____

Pelvic Therapy Specialists has my permission to put my Health Savings Account or Credit Card(s) on file. I understand that my card will be charged if my insurance says I am responsible for a deductible or co-insurance after my insurance adjustments. **PATIENTS ARE RESPONSIBLE TO CHECK EXPLANATION OF BENEFITS. THAT IS THE AMOUNT WE WILL BE CHARGING YOUR CARD.**

_____ _____

Signature of Responsible Party Date

Please contact our office at 303-601-7495 and leave a voice message regarding any questions about your bill.

Financial Policy:

I hereby authorize Pelvic Therapy Specialists, PC to furnish information to insurance carriers concerning my diagnosis and treatment and I hereby assign to the physical therapist all payments for medical services rendered to myself or my dependants.

I understand that I am responsible for any amount not covered by insurance. All professional services rendered are charged to the patient. Your remittance is due upon receipt of your bill. The charges and statement will be emailed around the 30th of the month. On the 5th of the month after the statement has been emailed, the card on file will be charged. If a transaction is rejected, any account balance outstanding longer than 28 days will be charged a **$10 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.

Failure to make payment when requested is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable fee and hereby waive their right of exemption under the law of the State of Colorado and any other state. I have received a copy of Pelvic Therapy Specialists, PC financial policy and understand its content.

_____ _____

Signature of Responsible Party Date

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INFORMED CONSENT FOR ASSESSMENT OF THE PELVIC FLOOR AND GENERALIZED EVALUATION AND TREATMENT

I understand that with referral to physical therapy for a pelvic floor dysfunction and/or biofeedback, it may be beneficial for my therapist to perform a *muscle assessment of the pelvic floor*. Palpation of these muscles is most direct and accessible if done via the rectum. Pelvic floor dysfunctions include pelvic pain, urinary incontinence, dyspareunia (pain with intercourse), bladder or bowel dysfunction, or other similar diagnoses.

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

Treatment procedures for pelvic floor can include biofeedback, electrical stimulation, and/or manual techniques such as massage or soft tissue work.

The therapist will explain all procedures to be used in my treatment, and I may choose not to participate with all or part of the treatment plan.

Based on the information I have received from the therapist, I voluntarily agree to the standard assessment and treatment plans for my condition.

_____ _____

Patient or Guardian Signature Date

If you are currently having an infection of any kind, or have a, sensitivity to KY jelly or vinyl gloves, please inform the therapist prior to the pelvic floor assessment.

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CANCELLATION AND NO-SHOW POLICY

We are committed to exceptional patient service and clinical care to expedite the healing and recovery process. To accomplish this, it is extremely important that you attend each of your scheduled appointments.

- **Scheduling** is based on a first come, first served basis. It is advisable for you to schedule your appointments in four to six week intervals (if needed) to ensure treatment continuity, as schedules are **commonly booked** for the immediate two weeks.

- In the event that you need to cancel an appointment, **we request at least 24 business hours notice**. Cancellation less than 24 hours can mean that we may not be able to schedule another patient who may be in need of our services.

- In the event of a late cancellation or "no-show," **your account will be assessed a $60 cancellation fee.** This charge will **not be covered by insurance** but will have to be paid by you personally**.** By signing below you **authorize permission for Pelvic Therapy Specialists to run your credit card** at the time.

- We understand that emergencies do occur – late cancellation due to severe weather, illness and family emergency is excluded from this policy. For women, internal treatment while having a period is common. Additionally, we may be able to work on secondary areas that may be a part of your pain and/or symptoms.

- **Arriving on time for your appointment is critical** to the optimal delivery of care. Chronic late arrivals are disruptive to the successful implementation of your patient care plan. Appointment times will still end at the scheduled time regardless of what time you arrive.

I understand the terms of this form. I agree to be financially responsible to pay for charges incurred from cancellations made less than 24 hours or no shows. I authorize Pelvic Therapy Specialists, PC to charge my credit card in the event of a cancellation or no show.

_____ _____

Patient or Guardian Signature Date

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HIPAA PRIVACY NOTICE

If you have questions and/or would like additional information regarding the uses and disclosures of your health information, you may contact our Privacy Officer at:

Pelvic Therapy Specialists, PC
c/o Sandra Shevlin, DPT
777 29th Street, Suite 102
Boulder, CO 80303
Ph 303-601-7495

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. Complaints filed directly with the secretary must be made in writing, name us, describe the acts or omissions in violation of the privacy rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted to us must be in writing and to the attention of our Privacy Officer. There will not be retaliation for filing a complaint.

By signing below, I hereby acknowledge receipt of this privacy notice.

_____
Patient Name

_____ _____
Patient or Patient's Representative Signature Date

_____
Representative's Relationship to Patient (if applicable)

Office Use Only:
To be completed by Pelvic Therapy Specialists, PC:

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s) _____
_____

_____ _____
Pelvic Therapy Specialists Representative Signature *Date*