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Pediatric Informed Consent

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my child's condition.

I acknowledge and understand that my child has been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, or pelvic pain conditions.

I understand that to evaluate my child's condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. **No internal examination is done.** This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and education instruction.

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records: I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists.

Patient Name: _____ **Date:** _____

Parent or Guardian Signature: _____

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NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

> **This notice describes how health information about you as a patient may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.**

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your personal health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time. You may at any time access, copy, and amend your records, request confidential communications, obtain accounting of disclosures that require authorization, and place restrictions on the use of your PHI.

We may use and disclose your PHI in the following ways:

- TREATMENT: PHI may be disclosed to healthcare providers or others assisting in your care.
- PAYMENT: Our practice may use and disclose your PHI in order to bill and collect payment for the services rendered. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will pay for treatment. PHI may also be sent to attorneys in lien or third party actions for payment.
- HEALTHCARE OPERATIONS: Our practice may use and disclose your PHI to operate our business including but not limited to the evaluation and review of the quality of care you received from us by our physical therapy provider network, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations. Finally, our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

All other disclosures of your personal health information will be made only with your written authorization and you may revoke that authorization at any time.

If you have questions about this Notice, please contact Rachel Miller PT, MS, WCS, CFMT, Owner, Empower Physical Therapy, Inc. Effective 09/20/2016

Patient Name: _____

(Please Print)

Patient/Guardian Signature: _____ **Date:** _____

I have been made aware and understand this Notice

Witness Signature: _____ Date: _____

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PAYMENT AND COLLECTION POLICY

Payment is expected at the time of service. Unpaid balances left by your insurance companies will be your responsibility. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Cash, money order, and/or HSA, HRA, MasterCard, Visa, American Express and Discover are accepted forms of payment on the account.

Please be advised that Empower Physical Therapy is not a credit grantor and therefore, failure to maintain payment arrangements may result in the placement of your account with a collection agency or attorney for collection.

Collection Policy: **In the event that you fail to pay as agreed or as the terms state, you agree to pay any and all collection fees, attorney fees, court cost or recovery costs. Please avoid this by keeping up with your payments and communication with the office staff.**

- ☐ **HEALTH INSURANCE:** Primary insurance will be billed by Empower Physical Therapy as a courtesy to you. Patients are responsible for knowing their own insurance benefits for physical therapy. Payment of insurance benefits is not forthcoming on chargers older than 60 days; therefore outstanding charges regardless of insurance carrier will be due by the patient above and beyond co-pay, co-insurance, deductible, and/or primary coverage classified as "above usual and customary" upon receipt of the Explanation of Benefits.
- ☐ **MEDICARE:** Medicare will pay 80% of Medicare approved charges; therefore 20% will be collected as a co-insurance. Please check your Medicare Handbook for details about capitation and run-out benefits.
- ☐ **WORKERS COMPENSATION AND MOTOR VEHICLE ACCIDENTS:** Patients will be asked to provide the following information: Date of Injury, Claim Number, Billing Address, Medical Payment Coverage and any authorizations required for services to be rendered. We will obtain a copy of your health insurance card for submission of any balance not covered. The patient is responsible for any balance not covered.

Patient Name: _____
(Please Print)

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ Date: _____

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Attendance Policy
(Please read thoroughly)

Empower Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Failure to keep your scheduled appointments hinders our ability to provide the best care to our patients. **We expect 24 hours notice prior to re-scheduling or canceling an appointment.** This allows us the opportunity to offer that time slot to another patient (from the waiting list) and we can re-schedule your appointment so that you do not have to miss out on your visit(s). We must ask your full cooperation with the following attendance policy:

- If you are more than 15 minutes late for your appointment and fail to notify us, treatment will be cancelled and a fee charged for missing the appointment. Two (2) cancelled or no-show visits without 24 hours notice will result in all remaining appointments being removed from the schedule and discharge from physical therapy
- Failure to give Empower Physical Therapy the necessary 24 hours notice will result in a "No Show Appointment Fee"
- THE FEE CANNOT BE BILLED TO YOUR INSURANCE COMPANY AND WILL BE DIRECTLY YOUR RESPONSIBILITY

The Physical Therapy No Show Appointment Fee is as follows: $75 fee for the Initial Evaluation and $50 fee for all other appointments.

You will only be charged if you do not provide appropriate notice for your cancellation. All phone messages are received and recorded in a timely fashion. This policy applies to all patients, including worker's compensation.

Please Read The Following Information Carefully

By signing below, you understand Empower Physical Therapy will charge you **$50** for no-show appointments with less than 24 hours notice or cancellation.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone.

All worker's compensation patients that are absent in the above descriptions will be noted to the Workers Compensation Insurance by phone contact and progress note.

Patient/Guardian Signature_____ **Date** _____ / _____ / _____

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Pediatric Pelvic Floor Patient History

Name of Parent or Guardian completing this form: _____

Child's Name: _____ **Preferred Name:** _____

Sex Assigned at Birth: _____ **Gender Identification:** _____ **Preferred Pronouns:** _____

Age: _____ **Grade:** _____ **Height:** _____ **Weight:** _____

Describe the reason for your child's appointment: _____

_____

When did this problem begin? _____

Is it getting worse, better or 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: _____

_____

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 to sleepovers, ect. _____

_____

Does your child now have or had a history of the following?

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: _____

_____

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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 that they need to go to the toilet? **Y/N**
5. How long does your child delay going to the toilet once they need to urinate (check one)
   - Not at all _____ 11-30 minutes _____
   - 1-2 minutes _____ 31-60 minutes _____
   - 3-10 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 or Very Small _____
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? **Y/N**
13. Fluid intake (one glass is 8oz or 1 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 them feel like they can't wait to go to the toilet? (i.e. running water) **Y/N** _____

Bowel Habits

15. Frequency of movements: _____ per day, _____ per week. Consistency: loose, normal or 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 their 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)
   a. Never _____
   b. When playing _____
   c. While watching TV or video games _____
   d. With strong cough/sneeze/physical exercise _____
   e. With a strong urge to go _____
   f. Nighttime sleep wetting _____
2. Frequency of urinary leakage- # of episodes
   a. Per month _____
   b. Per week _____
   c. Per day _____
   d. Constant leakage _____
3. Severity of leakage (check one)

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   a. No leakage _____
   b. Few drops _____
   c. Wets underwear _____
   d. Wets outer clothing _____
4. Bowel Leakage (check all that apply)
   a. Never _____
   b. When playing _____
   c. While watching TV or video games _____
   d. With strong cough/sneeze/physical exercise _____
   e. With a strong urge to go _____
5. Frequency of bowel leakage- # of episodes
   a. Per month _____
   b. Per week _____
   c. Per day _____
6. Severity of leakage (check one)
   a. No leakage _____
   b. Stool straining _____
   c. Small amount in underwear _____
   d. Complete emptying _____
7. Protection worn (check all that apply)
   a. None _____
   b. Tissue paper/paper towel _____
   c. Diaper _____
   d. Pull-ups _____
8. Ask your child to rate their feelings as to the severity of this problem (from 0-10 with 10 being major problem) _ _____
9. Rate the following statement as it applies to your child's life today: (from 0-10 with 10 being completely true)
   My child's bladder is controlling their life _____