EMPOWER
PHYSICAL THERAPY
Excellence. Compassion. Results.

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have 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, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand in order to evaluate my condition **it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination**. This examination is performed by observing and/or palpating the perineal region including the vagina, penis, and/or rectum. This evaluation will assess skin condition, reflexes, muscle length, tone, strength and endurance, scar mobility and function of the pelvic floor region.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercise, soft tissue and/or joint mobilization and educational instruction.

Potential risks: I may experience an increase in my current level of discomfort or pain, 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 therapist.
Potential benefits: 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.

Videos / Pictures: For safety and security reasons: You may ask your therapist to take pictures and/or videos of you doing your exercises so you can reference at home. Any pictures or videos taken at Empower Physical Therapy are for educational purposes only and **CANNOT** be shared in any format (via email, phone, internet, social media…)

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 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 my physical 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 physical therapy 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 and to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists. I have the right to receive the medical records generated by Empower Physical Therapy for a reasonable copy fee.

Patient Name: _____
(Please Print)

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

Witness Signature: _____ Date: _____

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PAYMENT, COLLECTION, AND ATTENDANCE POLICY

Empower Physical Therapy makes every effort to verify insurance coverage for physical therapy services. **Verifying coverage is no guarantee of payment.** We will submit the claims to your insurance company and attempt to secure payment. Ultimately, it is the **Clients Responsibility** to be aware of insurance coverage. Empower Physical Therapy has the right to collect co-pays, co-insurance and/or deductible amounts at the time of your visit.

I certify that I am covered by _____ Insurance Company and I assign directly to Empower Physical Therapy all insurance or workman's compensation benefits otherwise payable to me. I hereby authorize Empower Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I understand that I am responsible for any balance **not covered** by my insurance per usual and customary rate.
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.

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.** 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.

PLEASE CHECK THE APPROPRIATE BOX:

- ☐ **HEALTH INSURANCE:** Primary insurance will be billed by Empower Physical Therapy as a courtesy to you. 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.
- ☐ **WORKERS COMPENSATION AND AUTO 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.
- ☐ **SELF PAY:** Self pay patients are required to pay each visit. We can provide a financial summary so patients can submit to insurance.

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.**

Due to a high number of cancellations and accounts in collections, we now require a credit card to be on file.

Credit Card Number: _____ **Expiration Date:** _____

CVV: _____ **Billing Zip Code:** _____

By singing below, you understand and authorize the following:

1. **Empower Physical Therapy to keep your credit card on file.**
2. **Empower Physical Therapy to charge your credit card for a no-show or late cancellation with less than 24 hour notice.**
3. **Empower Physical Therapy to charge your credit card for any outstanding balance you may have.**

Patient Name: (Please print) _____

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

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: _____

PELVIC FLOOR PATIENT HISTORY

Name: _____ Age: _____ Sex Assigned at Birth: _____

Gender Identification: _____ Preferred Pronouns: _____

Height: _____ Weight: _____ Occupation: _____

Current/Past Smoker? If yes, how much: _____ How many alcoholic drinks per week? _____

How many cups (8oz) of water do you drink per day? _____ How many caffeinated beverages do you drink per day? _____

Date of Onset: _____ Describe the current problem: _____

What is your goal for PT? _____

If pain is present, rate pain on a 0-10 scale with 10 being the worst: _____

Describe the pain (ex: constant, comes & goes, ect.)_____

Is the pain staying the same, getting worst, or getting better? _____

Painful intercourse? Y/N Urge sensation? Y/N How many times a day do you urinate? _____

When do you lose urine? _____ How many pads do you use per day? _____

How often do you have a bowel movement? _____

Describe any previous treatment or exercises: _____

What relieves your symptoms? _____

What activities aggravate your symptoms? Check all that apply:

_____ Sitting greater than _____minutes
_____ Standing greater than _____ minutes
_____ Walking greater than _____ minutes
_____ Changing positions (sit to stand)
_____ Light housework
_____ Exercise (____ days/week)
_____ With cough/sneeze/strain
_____ With lifting/bending
_____ With cold weather
_____ With anxiety
_____ Sleeping
_____ Other: _____

Sleeping Questions:

How many hours of sleep do you get per night? _____

Do you fall asleep easily? ____ Yes ____ No

Do you wake up in the middle of the night? ____ Yes ____ No If yes, how many times is it to urinate? _____

Do you wake up feeling refreshed? ____ Yes ____ No

Do you take any medications and/or supplements to get to sleep? ____ Yes ____ No

Since the onset of current symptoms, have you had any of the following?

Y/N Fever/Chills
Y/N Unexplained weight change
Y/N Dizziness/Fainting
Y/N Change in bladder/bowel functions
Y/N Unexplained tiredness
Y/N Unexplained muscle weakness
Y/N Night pain/sweats
Y/N Numbness/tingling

Current Level of Stress: _____High _____ Medium _____ Low

Have you ever had any of the following conditions or diagnosis? Check all that apply/describe:

Abuse	Head Injury	Joint Replacement	Scoliosis
Adhesive Tape Allergies	Headaches	Kidney Disease	Seizures
Anemia	Hearing Loss	Latex Sensitivity	Spinal Cord Injury
Anxiety	Heart Problems	Low Back Pain	STD's/Abnormal PAP
Arthritic Condition	Hepatitis	Lyme Disease	Stress Fractures
Asthma	High Blood Pressure	Lack of Menstruation	Stroke
Cancer	HIV/AIDS	Multiple Sclerosis (MS)	Thyroid: Hypo
Childhood Bladder Problems	Incontinence (urinary/bowel)	Osteoporosis	Thyroid: Hyper
Chronic Fatigue	Infections	Pacemaker	TMJ/Neck Pain
Depression	Painful Intercourse	Pelvic Pain	Urinary Tract Infection
Diabetes	Interstitial Cystitis (IC)	Prostate Enlargement	Vision Problems
Eating Disorders	Irritable Bowel Syndrome	Rayanud's (cold hands & feet)	Other:
Emphysema	Irregular Vaginal Bleeding	Rheumatoid Arthritis	# of Pregnancies _____
Fibromyalgia	IUD (intrauterine device)	Sacroiliac/Tailbone Pain	# of Deliveries _____

Patient Contact/Emergency/Medications/Surgery Information

Patient Name: _____

I give my permission for messages to be left at the phone number(s) & email listed below:

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Emergency Contact & who we may speak with regarding your case:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

List any/all medications you are currently taking (including prescription, over the counter, herbals, vitamins, minerals, dietary, birth control)

Name of Medication	Dosage	Frequency	Taken How?

List any operations (with date) that you have received:

Operation	Date	Operation	Date

List any X-Rays/MRI's(with date) that you have received:

X-Ray/MRI	Date	X-Ray/MRI	Date